HARVARD MEDICAL

ALUMNI BULLETIN WINTER 1983

Student Life

Since 1812, The New England Journal of Medicine has played its role in medical circles—reporting the progress of medicine to physicians and medical students throughout the world.

The New England Journal of Medicine

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HARVARD MEDICAL

ALUMNI BULLETIN / WINTER 1983 / VOL. 57, NO. 1

FEATURES

DEPARTMENTS

About the cover: Evan Loh '85 dons his first white coat on day one of Introduction to Clinical Medicine at Massachusetts General Hospital. Photograph by Jerry Berndt. For more of that day, see page 32.

INSIDE H.M.A.B.

One day at the end of January this editor sat in a long room at Massachusetts General Hospital watching groups of second-year students shift their attention for the first time from lecture and lab to each other's bodies, to skin, blood, breathing, color, texture: first attempts to hook a subject's arm under one's own while adjusting a pressure cuff, an unsupervised blow to the inside of an elbow with a reflex hammer. Then one of them looked at me with sudden interest. I could see it dawn on him, and then on his cohorts: I was flesh and blood. I had a pulse. "Would you mind?" he asked, eyeing my arm. It struck me that he had become doctor and I patient, that I was witness at that moment to a critical transformation. I was not alone: the scene was also observed, and captured, by photographer Jerry Berndt. The results can be found in the center of this issue.

Earlier in the day, Alan Goroll, director of Introduction to Clinical Medicine at the MGH, had told the students, "We are going to teach you to tolerate uncertainty." That talent, we have learned in putting together this issue, has become a necessity—and not only in ICM. As articles here on their living arrangements and social organizations reveal, students today face unprecedented ranges of personal freedom and professional choice. With the rising cost of education, diminished financial aid, predictions of a physician glut, and the growing squeeze on the health dollar, as Dan Federman and two students tell us, they also face futures far more uncertain than those of previous generations.

Also in this issue, to further explore the ways in which times have changed, three students and their alumni fathers discuss HMS then and now, and George Washburn's (HMS 1886) letters tell us the way things once were. Finally, Robert Coles looks for warmth in the Longwood medical area, and finds it in the ongoing struggle "on behalf of the very lives of human beings"—warmth, in short, generated by those who have learned to touch others.

—LWD

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ALUMNI BULLETIN

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LETTERS

Piqued Memories

Giants Revisited

John Merrill's stories of the HMS giants in the Summer 1982 issue brought back the enjoyment and privilege that our class had in knowing most of those men, at least from a distance. We were not even too late for Walter Cannon and Lawrence Henderson. Among those who gave us their enthusiasm, dignity, and honor were Sidney Farber, John Enders, and S. (for Simeon) Burt Wolbach.

There is an Elliot Cutler story that John Merrill may not know. Either it is apocryphal or Dr. Cutler told it on himself. One hot July day Cutler was driving his car toward town on the soft and simmering asphalt of Huntington Avenue when he came upon a three-car smashup that had just happened. A short man in a business suit, bent over forward and shuffling backward away from the wreck, was dragging an elderly and unconscious woman by her arms. The sharp ends of her tibias were sticking out of her fractured legs and scraping along the pavement.

Dr. Cutler was outraged. He jammed on his brakes, bolted out of his car, and seized the man by the shoulder. Tall, imperious, and heroic, he stopped the man in his tracks and sternly announced, "Here, I'll take care of this!" The smaller man shook himself free of Cutler's grip without even looking at him. He kept right on dragging the woman and gave Dr. Cutler a snarl of contempt: "Get away, you fool. I'm a doctor!"

—Tom Coleman '44

Truth and Consequence

Patricia Spain Ward's article on the Cabot brothers in the Fall 1982 issue was most enjoyable.

My own interest in Hugh Cabot dates back to the late 1940s. I was a resident in the Section of Urology at the University of Michigan. Dr. Reed Nesbit, the service chief (having some years previously succeeded Hugh Cabot), told an anecdote which he attributed to Dr. Cabot: in the early 1930's he and Dr. Cabot were to demonstrate the use of cystoscope to a regional Urological Conference in northern Michigan.

With the patient properly anesthetized, Dr. Cabot inserted the scope and felt it "click" on a bladder stone, thus verifying its presence. Much to his horror, however, when he looked through the scope the light was broken; he couldn't see a thing. He then called on the oldest (presumably blindest) urologist in the audience to look through the scope and verify the presence of the stone. Surprisingly, a volunteer confirmed the presence of a stone through the functionless scope, and Dr. Cabot later performed a satisfactory superpubic removal.

Again, I enjoyed the article immensely.

—J. Tate Mason, M.D.
Seattle, Washington

Your coverage of the Bicentennial Convocation in the Fall 1982 issue makes interesting, in places inspiring, reading. But the article of illuminating interest to me is "The Medical Brothers Cabot," by Patricia Spain Ward—a scholarly, most instructive treatise concerning these masterful men and their family.

Richard was one of my professors: from 1917 to 1921 he, along with Harvey Cushing, Robert Greene, and others, made radiant those days at HMS. Richard's Pathological Case Histories remain to this day as clear and brilliant as they were in that distant time. His scholarly, analytical mind startled us constantly. I still treasure the handouts he gave us.

But Patricia Spain Ward's telling of the Cabot family saga, and the pictures of Richard, Hugh, and their equally brilliant brother Edward, along with those of the parents and the family group, all combined to make the article precious to me beyonds words.

Thank you, Miss Ward, and thank you, *Alumni Bulletin!*

—Clark Young '21

Encyclopedia Needed

The Roxbury Tenants of Harvard are seeking the donation of a recent encyclopedia set to the Mission Park Library in order to provide reference materials suitable for elementary and junior high school youngsters. The World Book encyclopedia has been recommended for this age group. Anyone who would like to see their underutilized encyclopedia set put to good use can contact Richard Doherty, Harvard Community Affairs Office, 2 Garden Street, Cambridge, MA 02138. Telephone: (617) 495-4955.

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. *Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the* HMAB *and may be edited, although we are unable to provide pre-publication proofs.*

PULSE

Verne S. Caviness, Jr.

Caviness First Kennedy Professor

A major clinical and research effort in the field of mental retardation has been launched at Massachusetts General Hospital with the establishment of the Joseph and Rose Kennedy Professorship of Child Neurology and Mental Retardation. The first of its kind at the MGH, the new position involves coordinating research and clinical activities on mental retardation at the MGH, the Eunice Kennedy Shriver Center for Mental Retardation, and McLean Hospital.

Verne S. Caviness, Jr., until now professor of neurology, has been appointed the first Kennedy Professor. Since 1976, he has been director of research at the Southard Laboratory of the Shriver Center. His major research interests are the development of the cortical structures of the mammalian nervous system, forebrain systems organization, human developmental pathology, and post-traumatic epilepsy.

The professorship, a gift of the Joseph P. Kennedy, Jr., Foundation and members of the Kennedy family, was announced last summer at the occasion of Mrs. Rose Kennedy's 92nd birthday. The family expressed the hope that the gift would enhance the quality of life for the mentally handicapped and lead to new approaches to the prevention of mental retardation. The endowment will also help expand the Joseph P. Kennedy, Jr., Laboratories of the Neurology Service, also at the MGH.

Walzer Appointed Gardner-Monks Professor

Generations of Gardners and Monks—including a line of three George Peabody Gardners—can be found in the history of the George P. Gardner/Olga E. Monks Professorship of Psychiatry, a newly formed post made possible by both families.

The first appointee to the new professorship is Stanley Walzer, professor and chief of psychiatry at Children's

Stanley Walzer

Hospital since 1981, and director of the Judge Baker Guidance Center. Walzer's research has focused on the development of children with sex chromosome abnormalities. From 1977 to 1981, as chairman of the Psychiatry Department of the University of Massachusetts Medical School in Worcester, he was deeply involved in developing community-based alternatives for the care of chronically ill psychiatric patients otherwise treated in state hospitals.

The Gardners' association with and support of Children's Hospital began with the hospital's inception in 1869. In 1946 G. Peabody Gardner established the Gardner-Monks Trust at Children's Hospital in honor of his father, George P. Gardner, and his father's sister, Olga E. (Gardner) Monks. G. Peabody Gardner was a trustee of CHMC for 49 years and an officer of the hospital's board. His son George P. Gardner, Jr., is now a member of the CHMC Board of Overseers.

Chatlos Professorship to Berson

With very few exceptions, retinitis pigmentosa, an hereditary degenerative disease of the retina which gradually blinds its victims, is not yet treatable. The little that can be done—early detection and counseling, and enhancement of night vision with the aid of a device called a pocketscope—has been the result of research by Eliot L. Berson '62, recently named the first William F. Chatlos Professor of Ophthalmology.

Established through a gift from the National Retinitis Foundation of Baltimore, the new professorship is named in memory of the grandfather of William J. Chatlos, a trustee of the foundation.

Retinitis pigmentosa strikes one in 3,700 people. It causes difficulty in adapting from light to dark or dark to light, night blindness, loss of peripheral vision, and eventual loss of central vision. Patients usually become symptomatic between the ages of 10 and 35, and about half are legally blind by 40.

During his tenure as clinical associate in ophthalmology at NIH from 1966 to 1968, Berson discovered that

Eliot L. Berson

progressive forms of retinitis pigmentosa can be diagnosed with electroretinographic (ERG) testing, often 10 or more years before symptoms develop or abnormalities are visible with an ophthalmoscope. The test will also distinguish the degenerative form of the disease from its self-limited form, and can detect carriers.

Berson brought ERG testing to Boston when he became an instructor at HMS in 1968. The test has since been generally adopted worldwide. In 1974 he established the Berman-Gund Laboratory for the Study of Retinal Degenerations at the Massachusetts Eye and Ear Infirmary, bringing together scientists with expertise in biochemistry, tissue culture, and electron microscopy. To further research on retinal diseases, he and his colleagues have set up an eye donor program, and have gathered a database on more than 3,000 patients. Berson will continue to serve as director of the laboratory.

Wanted: Able-Bodied Physician

Forty-five Harvard undergraduates need a physician to accompany them on an eight-week transcontinental bicycle trip. The goal is to raise $250,000 for Oxfam America, the worldwide hunger-relief organization. The trek begins on June 13 with a flight to Seattle; from there it's 3,800 miles back to Boston. If interested, telephone Susan Markush at (617) 498-6226. Call even if interested in half the ride (four weeks).

Second-Year Show: "A Christmas Camel"

"Life is in Building A," sings Carola Eisenberg (Sara Neilly), the Spirit of HMS Present in "A Christmas Camel." The vision of HMS Future includes Women's and Brigham Hospital, at which males are given IPDs (intrapenile devices) and are treated for excess testosterone, and the 24-year New Pathway, in which students are admitted as "little, tiny babies." Intermission and the gaps between scenes are filled by videotaped parodies of the Beatles (the B-Cells), television (Countway 5-0), and *An Officer and a Gentleman* ("Only two things come from Oklahoma, boy: steers and molecular biologists").

Professor Emphysema Scrooge (Mark Vierra) warns his students about next day's final exam: "You had better work your ass off, or repeat this course next fall."

Evan Loh as the "Zebra in Book."

Rodney Dangerfield (Freddy Orlando) complains that he gets no respect.

"In our little village of Anaplasia. . . " O.W. "Tevye" Holmes (John Triedman) introduces the song "Physician!"

Finale: "Once we thought it was beyond all hope; now can't you see us with our stethoscopes. We'll be wearing white and acting cool, when we get out of medical school!"

Remember to save the date:
June 8, 1983
8 P.M.
(during Alumni Week)

HMS NIGHT AT THE POPS

Please return your reservation forms soon if you have not already done so. For more information contact the Harvard Medical Alumni Association, 25 Shattuck Street, Boston, MA 02115.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr. Travelling Fellowship

Applications Invited for 1984-85

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

In considering candidates for the Moseley Travelling Fellowship, the Committee on Fellowships in the Medical School will give preference to those Harvard Medical School graduates who have —

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**
4. **Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be eligible for these awards.**

The Committee has voted that within the funds available the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 12 months in advance of the requested beginning date and in any event not later than December 31 of any calendar year. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31.

Application forms may be obtained from, and completed applications should be returned to:

Committee on Alumni Fellowships in the Medical School
Harvard Medical School
Building A — Room 414
25 Shattuck Street, Boston, Massachusetts 02115

The High Cost of Learning

by Daniel D. Federman '53

A Report from the Dean for Students and Alumni

Medical students have always had something to worry about. They wonder whether the content and quality of their instruction are preparing them for their future responsibilities. They personalize the illnesses they study and experience each one in turn. They agonize about their own adequacy, what field to enter, and combining a demanding profession with a personal and family life. But current students have a new concern: the cost of their education.

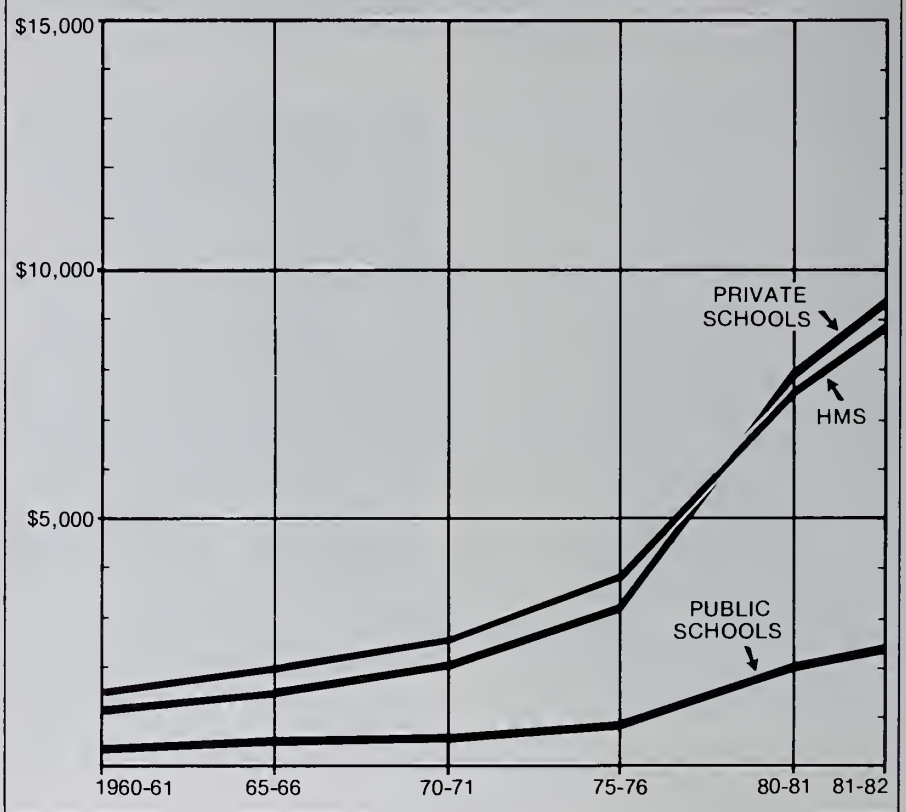
Few young adults have independent means sufficient to cover the costs of a medical education. In the past, most medical students were supported by their families and, to some degree, by their own earnings. Meeting the costs of this education required planning and considerable personal and family sacrifice. In effect, each generation was financed by the efforts of the preceding generation, the parents. The same principle still applies in publicly supported state schools. The cost of medical education in 1982-83 is thought to be about $25,000 per student per year; in contrast, tuition at state medical schools averages $2,675. The difference is paid out of taxes, reflecting the willingness of the state's citizens to support the production of new physicians.

The situation in the country's private schools, however, is radically different. Tuition at present ranges from $3,500 to $19,000, with a median of $10,350. Few students in these schools pay their own way. Although some obtain partial scholarship aid most rely primarily on loans. Thus their education is being financed not by gifts from the older generation, but by borrowed money that must be paid back.

History of Tuition and Costs

The past 20 years have seen striking changes in the costs of medical education (see Figure 1), in the sources of medical school support, and in the means by which students finance their educations. In absolute terms, tuition at public schools has risen fivefold; at private schools, ninefold. Adjusted to constant 1960 dollars, tuition has risen 1.6 times at public schools, and has almost tripled at private schools. As can be seen in the figure, HMS tuition has remained lower than the median of private schools. But there are costs other than tuition: even medical students have to eat, sleep indoors, get to classes and clerkships, and have a

Figure 1. *Median Tuition at Public and Private Medical Schools and at HMS.*



Just when the costs of attending medical school began to escalate, there was a major shift in the responsibility for payment from the family to the individual student.

little fun. These costs have risen less than tuition; in 1960, 43 percent of the student's total cost was tuition; in 1980 it was 58 percent (see Figure 2).

For the past two decades, the federal government has been a major source of support for private medical schools. From 1950 to 1965, federal grants for biomedical research and research training increased steadily. In the early '60s, inflation was minimal, and the cost of medical education rose slowly. By 1965 the federal government was providing up to 55 percent of the income of medical schools.

After 1965, the situation changed markedly. The federal commitment to

Guide to Financial Aid Acronyms

HEAL: Health Education Assistance Loan

FISL: Federally Insured Student Loans

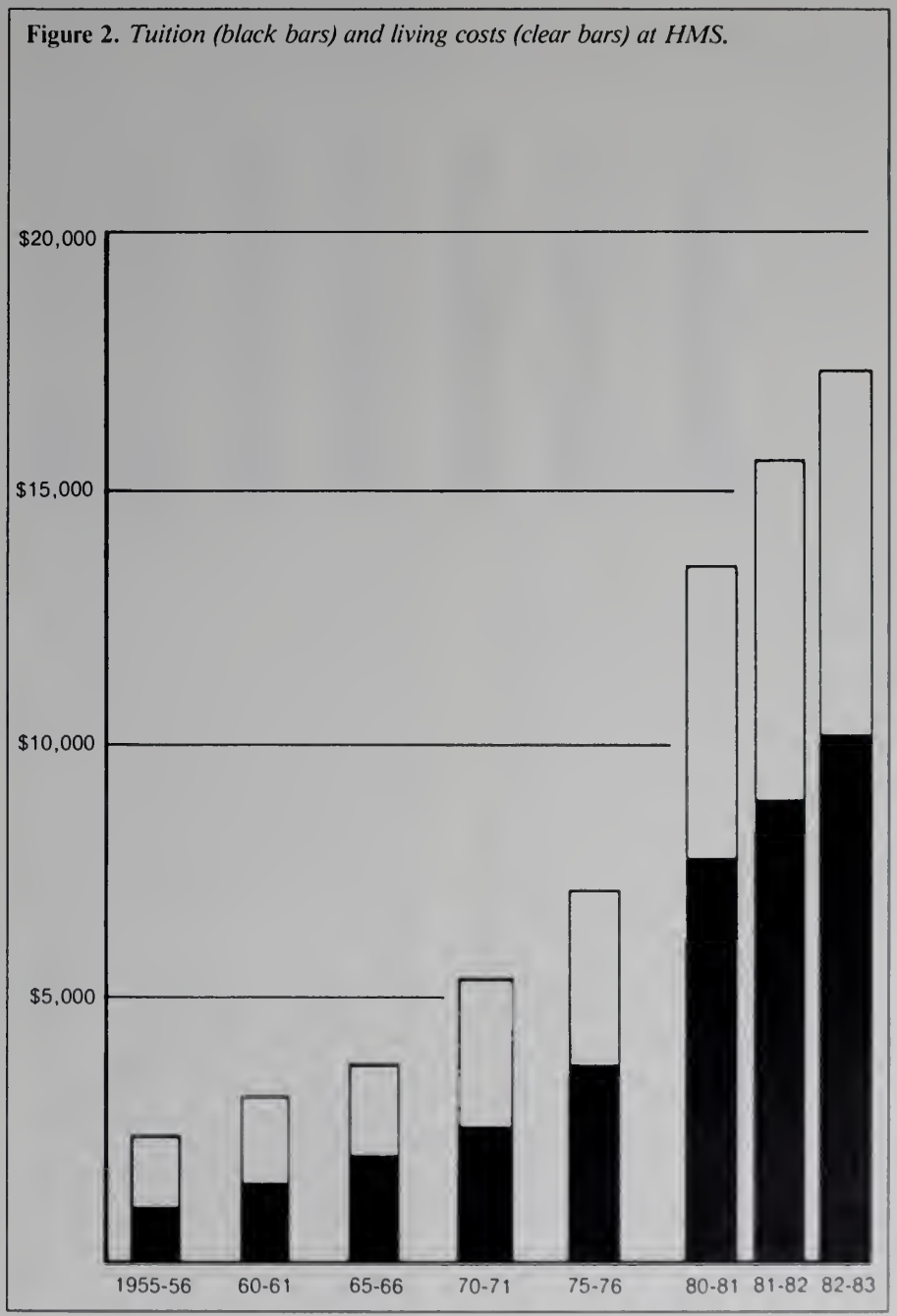
HPSL: Health Professions Student Loan

GSL: Graduate Student Loan

NDSL: National Direct Student Loan

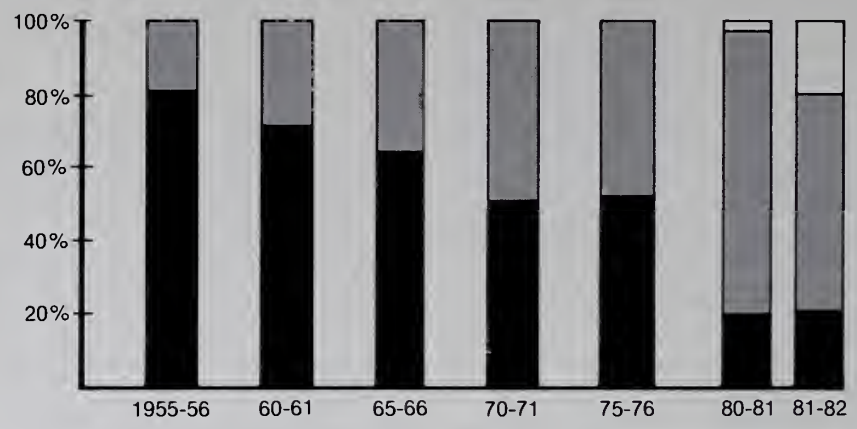
PLUS: Once the Parents Loan for Undergraduate Students, this loan can now be taken out by graduate students. Known briefly (and still in some states) as ALAS, for Auxiliary Loans to Assist Students, the name reportedly reverted to PLUS when a policymaker found the acronym ALAS too dismal. PLUS now generally means in addition to other loans.

Figure 2. *Tuition (black bars) and living costs (clear bars) at HMS.*



Colleges everywhere, in addition to medical schools, are seeing a decline in applications from students of modest and limited means.

Figure 3. *Student Expenses: Student and Family Contribution (black), HMS Financial Aid (grey), and loans at market-rate interest (clear).*



research declined, but was partially offset by support given directly to the schools, including, from 1971 on, capitation — payments per student, provided to encourage enlargement of medical school classes. Federal support peaked around 1975. Since then, medical schools have been increasingly responsible for their own financing: faculty clinical income and health care services have provided an increasing fraction of schools' income, and tuition has been increasing too.

The general inflation of the '70s was accompanied by a striking inflation in the costs of all higher education, including medicine. And just when the costs of attending medical school began to escalate, there was a major shift in the responsibility for payment from the family to the individual student. In 1955 the HMS student's family provided 83 percent of costs (see Figure 3). By 1980, only 20 percent came from this source; the rest was provided in good part through obligations acquired by the student.

Financing a Medical Education

How has the student's growing personal responsibility for his or her education been financed? The older alumni's image of financial aid is very different from what exists at present. Before 1960, less than a fifth of the class received financial aid, much of it scholarship. A few students took loans from the school or from local or state sources. In 1962 the first national loan program for medical students was initiated by the American Medical Association, which guaranteed privately made loans; interestingly, the guarantees were based on money contributed by private physicians.

The growing federal involvement of the 1960s not only changed the nature of medical school finance, it also changed the financial picture for students. In 1963, the federal government began to provide loans for economically disadvantaged medical students. In the late '60s and early '70s, both loan-forgiveness and scholarship support became available for individuals who agreed to practice in medically underserved areas, and the armed services offered scholarships in exchange for service. In addition, the FISL program made loans available without regard to need. This was particularly important to middle-class families who had several children in college or professional school simultaneously. Thus both disadvantaged and middle-class students gradually assumed a pattern of borrowing to attend medical school.

The Present Financial Situation

Where are we now? In brief, the supports that had allowed medical school classes to grow and students of modest or little means to attend private schools are being knocked out. The severe inflation of the early 1970s — temporarily masked by capitation and low-interest loans — is revealing its true slope. The federal role is diminishing yearly: capitation is gone, National Health Corps Scholarships are being phased out, biomedical research support is weakening. Students faced with high expenses find that low-cost financing is no longer readily available. What is more, the psychological setting of medical education has altered in at least three ways. First, the perception of a physician shortage has been replaced by predictions of a physician glut — that is, there is less of a perceived need to encourage the production of doctors. Second, public concern about the cost of health care has mounted. Third, the transfer of responsibility for unmet financial need from parents to current students is now firmly established in public expectations and is unlikely to be reversed.

At almost all private schools, financial aid is based on need. To determine this need, the Financial Aid Office compares each student's resources

Are Harvard Medical Alumni Delinquent?

In December 1981, a Senate subcommittee (the Energy, Nuclear Power and Government Processes Subcommittee of the Appropriations Committee) held hearings on repayment by nurses, dentists, and doctors of one type of federal loan they had acquired as students, the Health Professions Students Loan. In the course of these hearings, doctors in general and HMS alumni in particular were severely criticized for failure to repay their loans on time. I believe HMS alumni are entitled to an explanation.

The Health Professions Student Loan (HPSL) is a relatively small part of the loan portfolio acquired by most medical students; at HMS it comprises about five percent. Students pay no interest on HPSL loans while they are in medical school, and repayment can be deferred until the completion of residency and fellowship. At that time the loans begin to bear nine percent interest and must be repaid in 10 years. Grounds for deferring repayment, such as being in fellowship, must be authenticated yearly.

When Senator Charles Percy called attention to problems with HPSL repayment, numerous schools, Harvard among them, were found to have many alumni who were behind their *originally predicted* repayment schedules. In the view of Harvard's collection offices, most of this tardiness was more apparent than real. Careful analysis showed that many alumni were still in training but had not completed deferment forms necessary to document their status. Others were making regular payments which, for technical reasons, had not been allocated to the HPSL portion of their debt. Some alumni were unable to pay because their incomes were still very limited. Some, however, were truly, and inexcusably, late.

The hearings helped reveal the ambiguity of the definition of delinquency in the HPSL program, a definition very different from that used for other loan programs. Anyone who had once fallen behind HPSL payments but then resumed regular payments was considered delinquent until the once overdue amount, however small, was made up. Another difficulty was that the schools were severely constrained in the collection efforts allowed by the federal regulations. For these reasons, Harvard's Fiscal Office found that most of the apparent delinquency of HMS alumni was due to errors in processing and documentation, and not to true failure to repay. This conclusion was not accepted by the Senate staff, however, and the published figures cast our alumni in a very negative light.

All this has now changed. The government has authorized more effective collection procedures, defects in documentation have been corrected, and most of the alumni who had fallen behind their properly expected payments have caught up. Although there are still a few alumni who are not making the payments they should, the number is nowhere near what has been claimed in the press. On October 13, 1982, the figures were as follows:

Number of payors more than 90 days late	75	= 10.6% delinquency
Number of persons making payments	705	

Some of these persons are paying at an increased rate to catch up with previous tardiness that is still technically uncorrected. It is thus more useful to express the delinquency as:

Amount more than 90 days overdue	$79,409	= 3.9% delinquency
Amount being repaid	$2,022,779	

Although there remain a very small number of alumni who are truly delinquent and even defaulting, HMS's status now compares favorably with the best records of other schools.

– D.D.F.

to his or her need. For example, this year at HMS the total expense of tuition plus living costs is about $18,000. The family resources are evaluated by figuring income and assets, costs for other children in post-secondary school, and the student's own ability to pay. On the basis of this information, an expected family contribution is calculated; the difference between the student's financial need and the expected family contribution is the financial aid award.

The initial component of the award is not scholarship, but loan. A student must borrow an amount known as the "unit loan" before becoming eligible for any scholarship. If the calculated need is less than the unit loan, all of the aid will be in the form of loans. If the need exceeds the unit loan, the aid is made up of a mixture of loan and scholarship. This approach has been in effect for over 10 years. For much of that time, low-interest loans were available. The student bore no interest liability until education was completed; depending on the type of loan, either the government or HMS subsidized the interest in the interim. Because the simple interest was low, and because the loans were subsidized, the cost of repayment was largely offset by the then high rate of inflation. In other words, up to about 1980 the indebtedness acquired by students was almost entirely in favorable loans with tolerable repayment schedules.

Recent graduates, however, find a financial picture dramatically different from those of previous classes. Their personal indebtedness is far greater than that of their predecessors, and they owe debts to several loan programs, all at a time when the country is said to have too many doctors. Some of these loans bear market-rate interest, which begins compounding im-

Our students' cumulative indebtedness may soon threaten achievement of some of HMS's most treasured goals.

mediately, even though repayment is deferred. In recent years, market rate has been as high as 18 percent — at which rate the loan doubles every four years.

Consider the indebtedness of recent graduates. The class of 1982 had the following profile:

Cumulative Debt at Graduation	Number of Students
$ 5,000-19,999	46
20,000-29,999	20
30,000-39,999	50
40,000-49,999	6

These days, the *type* of loan is as important as the *amount* of loan in predicting its impact. The duration of repayment and the rate of interest — including such factors as whether interest accumulates while the student is still in training and whether it is simple or compound — are even more important than the amount. For the class of 1982, all but five percent of the loan was what is (almost ironically) called "good loan" — that is, loan bearing simple interest of nine percent or less, subsidized during school and deferment periods, and with a reasonably long payback period. For the class of 1983, however, about 80 percent of the loan will be "good," but 20 percent will bear unsubsidized market-rate interest, and will have to be paid back in just 10 years. Unless something changes, we anticipate that the class of 1986 will have almost half its debt at market-rate interest. If this interest were to remain at the recent 18 percent level, we would predict the following repayment patterns for the two classes:

	Class of 1983	Class of 1986
Median debt at graduation	$43,850	$66,500
Source of loans:		
Subsidized	80%	50%
Market-rate	20%	50%

Monthly Repayment Schedule

Postgraduate year	Class of 1983	Class of 1986
1	$169	$ 529
2	268	601
3	391	828
4	583	986
5	588	1001
6	618	1061
7	618	1061
8	525	1061
9	525	1061
10	495	1001
11	462	978
12	363	906
13	299	524
14	108	365
15	108	365
16	108	365
17	108	365
18	108	365
19	108	365
20	108	365
21	108	365
22	108	365
23	108	365
24	108	365
25	108	365

PAID UP AT APPROXIMATE AGE 50

These scales reflect the recent market-rate interest of 18 percent. That figure has recently moderated, and repayment schedules are therefore lower.

The Future

The costs of medical education are rising, the available scholarship and low-interest loans are inadequate, and the burden on a sizable number of our students is becoming intolerable.

Colleges everywhere, in addition to medical schools, are seeing a decline in applications from students of modest and limited means. If current trends continue, the student body in the United States' private medical schools may become representative more of ability to pay than of potential for medicine.

Harvard Medical School is no exception to these general trends. Some 80 percent of our students receive financial aid. Although we provide $1 million in scholarship and $350,000 in low-interest loans, our students' cumulative indebtedness may soon threaten achievement of HMS's most treasured goals.

The hope to draw students from all over the country, the desire to admit students without regard to their ability to pay, the students' freedom to choose their fields without economic constraints, the ambition to train future academicians, the hope that graduates will serve underserved groups — all are threatened by the changing financial scene.

The school is embarked on a budget adjustment process to try to reduce costs as much as possible without compromising academic quality. But new sources of aid are also needed if we are to maintain the goals that characterize Harvard Medical School. □

Facts and figures for this article were researched and compiled by Theresa Orr, director of financial aid at HMS.

Forever Indebted

The Impossible Dream

by Lewis Milrod '85

For the past few months I've had this recurring dream; some might call it a nightmare. I find myself seated on a bus gazing out the window. I seem to know the destination, but I am unsure of the return trip schedule and the estimated time of arrival. Road signs flash by. I see "Scholarship," "GSL*," "PLUS," and before I can avert my gaze the dreaded words "HEAL Last Exit Before 25 Year Toll" appear. Frantically, I try to signal the driver to turn around but, as usually occurs in dreams, the words just don't come out and we pass a sign that reads "No U Turn." At the toll booth, the driver does not stop and roll down his window. Instead, the toll collector insists that I accept the "ticket" with fees and milestones clearly marked but no exits indicated.

As the bus pulls away from the toll booth, the first sign of the turnpike comes into focus: "Third and Fourth Year – Quarterly Interest Payments." The dream ends after the passenger across the aisle identifies himself as Charlie on the MTA, the subject of that classic ballad, who finds that the "T" has raised its prices and he is unable to meet the payments. Consequently, he "will ride forever through the streets of Boston."

No doubt this dream is prompted by a letter that has been displayed for months on the bulletin board over my desk in Vanderbilt Hall. After explain-

continued on page 14

**See guide to financial aid acronyms page 9.*

Money Talk

by Hank Frissora '83

It has been four years now that I have been running around Boston, Cambridge, and Dedham signing for thousands with my Harvard "charge" like a manic at Bloomingdale's. Following each year's announcement of a tuition increase (during my four years at HMS, tuition has gone from $6,500 to $10,250) came the financial aid award allowing one to borrow that much more. Then came the lithium. Somebody told me we actually had to pay these loans back. I investigated; she was right.

Equipped with a calculator (I was trained as an engineer), I set about computing my grand total. The calculator began to smoke, then died. After hours of counting fingers, I came up with a grand total of $47,180 ($1,830 from undergraduate debt).

Using the principles of fluid balance, I decided to tally the prospect for the next 15 years of loan payback. Hopefully money in would balance money out. I plan to pursue a career in academic surgery. This entails approximately 8 to 10 years of training, broken down sequentially as follows: two years' general surgical residency, two years' basic science research, three years' completion of general surgical residency, two to three years' surgical specialty training and/or post-doctoral fellowships. At the age of 35, I will seek my "first" job.

Even after all those years of training, academics earn only about a third

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I find myself committed to a course of at least six more years of training and 10 to 25 years of loan payments.

The Impossible Dream

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ing that I'll need to take a bus to Dedham in order to sign the loan, the letter cautions, "Since interest will begin to accrue on that date, we suggest that you delay taking the funds until absolutely necessary." Yes, a $2,600 HEAL loan awaits my signature. And will be kept waiting as long as possible.

The HEAL loan has become a symbol to me, like the Citgo sign was to Charles LeBaron in *Gentle Vengeance*. Like Charlie on the MTA, I find myself on the road of medical education, committed to a course of at least six more years of training and 10 to 25 years of loan payments. Like Charlie, I got on the bus without realizing the full meaning of that decision. Indeed, the nature of financial aid in higher education has changed drastically within the past year. Last year I borrowed $9,450, all at the rate of nine percent or under, with government subsidy of interest payments while I'm in school. By the end of the current academic year, I will have borrowed an additional $13,100, $5,600 of which is at an interest rate of 12 percent or over, with interest accruing or being paid quarterly. (My father recently remarked that he spent little more for our first house than the amount I've taken out in loans this year.) My financial situation has changed from one of reasonable, manageable debt to potentially burdensome limitations.

It all seems unreal. I sign a few forms, Harvard accepts that as payment, and I don't have to worry about the implications for a few years. Meanwhile, however, there is the issue of day-to-day costs and the mandate that I live within the budget the Financial Aid Office has established, particularly with regard to the suggested contributions from parental and personal savings and earnings. If I do exceed these contributions, then next year, as the unit loan goes up, I will have less savings to dig into, and will have to borrow even more.

Somehow, you find yourself behind in the ballgame before you even start. The Financial Aid Office includes the GSL/FISL origination fee in its budget, but the quarterly interest payments that accompany a loan like HEAL are not included. Even more significant is the fact that if your financial need adds up to $13,100 in loans, as mine does, your loan checks do not add up to $13,100: several hundred dollars are taken out for various fees on such loans as PLUS and HEAL.

Basically, my loans cover tuition, fees, and room rent at Vanderbilt Hall. The rest of my expenses, including books, food, clothing, and other personal items, are met through summer earnings, personal savings, and parental savings. I have found myself in awkward financial situations when socializing with friends from the real world, who make real money. A few times, my classmates and I have actually been seated in a restaurant, only to decide upon viewing the menu that it was just too expensive. On other occasions big groups of people have split up, with one group going to a more expensive restaurant and the other to a more economical one. On dates, I've come to expect at the very least an offer to help with expenses. This has been a radical change from the social situation in college, where Southern etiquette required that a date involve both dinner and entertainment and be funded completely by the person who issued the invitation.

At 23, I feel I should be independent of my parents. But unless I take out more HEAL money, I can't be. In cases like this, the Financial Aid Office suggests a student/parent promissory note. To set out financial terms and actually sign a binding legal document with one's own family seems distasteful and uncomfortable. I've resolved to pay back what I can when I can.

My decision to attend college was made with the recognition that my younger brother and sister would also need my parents' resources to attend college and possibly graduate school. I was fortunate enough to receive a full academic scholarship in college and therefore graduated without debt. It hurts now to go home and see that my parents have made sacrifices to help support me: they don't go out to eat nearly as often as they used to, and they don't take any "real" vacations.

My father works at three jobs and my mother at two. If my parents had been lazy or had not put savings away in a responsible manner but spent money as they liked, would my brother, sister, and I have received more financial aid? Would my parents have ended up with the same amount of money in the bank? Such lines of reasoning lead to temptation. Since I'm already in debt, why not take out lots of loans and really live it up? This impulse is quickly dampened: I may borrow only up to the amount that the Financial Aid Office determines I need.

The option of borrowing more (thus reducing dependence upon my parents) and becoming more in debt personally has long-term career implications. As one who is considering a career in academic medicine, I feel that the economics of the moment will play a great role in my decision.

Doctor, HEAL Thyself

Depending on my marital status and indebtedness, I may have to decide whether an academic position would be worth it, or whether I should subspecialize, and thus reduce the financial pressures. Predictions of a physician surplus and cuts in the number of residency openings in the near future add to the general anxiety.

Lately, my nightmare plot has changed somewhat. Just after the bus passes the "HEAL Last Exit" sign, the driver turns to me and asks, "Shall we turn back?" After a pregnant pause, I reply, "No, I'm willing to pay the price." This may be the crucial difference between Charlie and me. Charlie is unable to pay the price; I may be unable, also, but I am willing to give it a try. □

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to a half as much as their colleagues in private practice. On average a first-year resident makes $18,040, with yearly increases of about $1,400. During research and fellowship years, salaries are notoriously low, often less than $18,000. Many residents and fellows I talk with find this salary barely livable, especially those with families.

Taking into account the allowed deferments, and the principal and interest payback schedules on my HEAL, PLUS, GSL, HPSL, NDSL, HMS, and Franklin Fund loans, I've derived the accompanying input and output chart.

Interest rates on the components of my total debt ($47,180) range from 6 to 17 percent. HEAL, although it accounts for only $6,250 of my debt, has the most injurious payback schedule. When I signed for the loan, it carried 17 percent interest: the Treasury Bill rate at the time plus 4 percent.

As can be deduced from the tables, more than half of my take-home salary may be required to meet payback demands. This is comparable to a stiff home mortgage, but without a place to stay (except a cot in the on-call room every other night). Unfortunately, surgical training requires Q. O. Noc. call duty, leaving precious little time available for moonlighting. Moonlighting, or ER weekend/night shift, is possible during research years — at the expense of family life, outside interests, and laboratory time.

Inflation also enters into the equation. Obviously, as the dollar is devalued, loans taken out on "old" money aren't worth as much. But this benefit is reaped only if salaries keep up with inflation. With massive cutbacks in hospital budgets and research and training programs, the income outlook for the training academician is grim.

What's the solution? Most loans are dismissed with death. Cashing in on ingenuity and my M.D., I could team up with an indebted colleague and we could sign each other off as legally dead. But somebody would surely catch on. An HMS administrator suggested I take two years off to work in emergency medicine in Saudi Arabia, but my Arabic is only rudimentary.

A surgeon suggested I take out an advertisement in the *Bulletin* with the plea: "I'm sinking. Please send help in the form of monetary contributions."

I may just do that. □

	Payment Schedule		Salary	
†*Year*	*Per Month*	*Per Year*	*Gross Per Month*	*Gross Per Year*
1-2	$270	$ 3,240	$1,580	$19,000
3-4	$610	$ 7,320	$1,800	$22,000
5-10	$920	$11,400	$2,000	$24,000**
11-12	$670	$ 8,040	$3,300	$40,000 (estimate)
13-15	$395	$ 4,740	$?	$?

†HEAL loan accounts for $92 per month years 1-4, $382 per month years 5-15.
***Represents approximate average for residency and fellowship salaries.*

ILLUSTRATED BY HANK FRISSORA

Be It Ever So Humble

In the early 1940s, Evan Calkins '45 tells us elsewhere in this issue, nearly all HMS students lived in Vanderbilt Hall barracks-style, two to a room. Today, Vanderbilt holds up to 284 students in 261 rooms.

All first-year students are guaranteed housing, and over three-quarters of them accept the offer. Occasionally, a few third- and fourth-year students are turned down for lack of space. Each fall the dormitory is filled to capacity. By January, 10 percent of the rooms are empty, and the vacancies continue to rise through the spring, as students decide to try apartment life.

As of February this year, roughly 29 percent of all students were living in Vanderbilt. Almost as many—24 percent—live in Cambridge; 17 percent in Brookline; 14 percent in Boston (including Brighton, Roxbury, and Allston); 3 percent each in Jamaica Plain and Somerville. The rest are scattered in various suburbs. A few own houses or condominiums; most rent.

Statistics tell only part of the story, however. To give us a better picture, editorial board member Dorene O'Hara '83 has evoked her Vanderbilt Hall days, and asked several of her classmates to describe how they live. From Hank Frissora's passion for Italian food and culture, to Ed Bromfield's appreciation of ethnic diversity, to Dorene's reminiscences of the convenience of Vanderbilt, the answers reveal as much about students' extramedical concerns and desires as they do about the range of housing possibilities for HMS students in the Boston area.

PHOTOS BY JERRY BERNDT

Brookline

by Peter Rintels '83

The movie *Altered States* would have you believe that immersion in a sensory deprivation tank could cause a Harvard scientist to revert to a subhuman, precivilized state of senseless barbarism. As a three-year resident of Vanderbilt Hall recently moved to a Brookline apartment, I have a better explanation for what happened to this man: he had simply been hanging around the medical area too much.

Well, I suppose someone is going to try to tell me that since I left Vanderbilt my brow ridges and canine teeth haven't receded, the hair hasn't thinned on my body, and that I don't walk on my knuckles any less than I used to. There's always a wise guy out there somewhere.

But I certainly feel more civilized now. No longer am I cleaning dishes in communal bathroom sinks clogged by people having already tried to do the same thing. Nor does an overhead paging system keep me up to date with the comings and goings of people whose comings and goings I really don't care about. And I have fought my last skirmish in the "dueling stereos" brand of guerrilla warfare between competing musical tastes.

Nowadays, schedule permitting, I retire in the evenings to a quiet suburban apartment, eight minutes by bicycle from the medical area, but otherwise a world away. To get in, I merely unlock the door; I don't have to first prove to a security guard that I'm not a criminal. Once there, I can sink into a comfortable living room chair, perhaps browse through my *Newsweek*, have a nip at whatever is around to be nipped at, and blissfully let the TV news make sure I haven't missed hearing about any interesting murders, assaults, or fires around Boston. That's pretty close to being civilized, isn't it? Oh yes, the pots now get washed in a sink with a garbage disposal, and the dishes go into a dishwasher.

I now talk about "going home" at night with more conviction. Dormitories suddenly seem, as the name suggests, merely places to sleep; apartments are places to live. Had I been asked to write this article two years ago, I would probably be extolling the virtues of dorm life—cheap, convenient, lots of people around—but during third year, as the hospital hours grew longer and began to weigh more heavily, I grew restless for a change of scenery. Also, Vanderbilt rents have been rising steadily over the past years, usually 15 percent, so dorm life is not the bargain it used to be. Meanwhile, my current landlord has frozen our rent ($475 plus utilities, split three ways) for as long as we stay, in order to keep his quiet, non-destructive medical student tenants.

To be sure, there are reasons for civilization to have its discontents. It was nice having indoor basketball and squash courts a few feet away. It was nice having the *Times* delivered to the lobby every morning. It was nice having a mailman, Harold, who knew my name.

My new home—a three-bedroom, third-floor walkup in a fairly nondescript part of Brookline—came to me much as I did to it. An apartment-dwelling friend of mine recently got married, and when it was discovered that the addition of a wife could not be reconciled to the sharing arrangements he had with his roommates, he moved out and I filled the vacancy.

The neighborhood is mainly residential, but within a block are the major lifeline businesses: a laundromat, a grocery, and a liquor store. Local color is provided by an incomprehensible establishment called Kendall Variety, the sparse shelves of which offer a total of about two dozen items, including bundles of old newspapers, a canned food section consisting of creamed corn and tomato paste, detergents, soft drinks, home remedies, and car wax. All this notwithstanding, the only things I have ever seen anyone *buy* there are newspapers, coffee, and muffins from the lunch counter. The proprietor is a stooped, old fellow who seems to have come to this country with a phrasebook vocabulary of: "Globe? Twenty-five cents," "Muffin? Apple or blueberry?" and "OK, OK."

The neophyte apartment dweller was soon to discover that moving was only half the battle. Fortunately, my new roommates (Mark Ditmar '83 and Kevin Cullen '83) had already established a homestead with the basic necessities: utensils, dishes, living room furniture, coffee machine, and a television. In return, my major contributions have been a mechanical monkey which greets visitors from the top of our TV and a willingness to go across the street for the morning paper ("Globe? Twenty-five cents.") in even the most wretched weather.

Meanwhile, however, my new room sported only a bed, which I bought from my friend, and several items he was content to just leave behind, including an alleged dresser—more like a dresser-shaped piece of cardboard—and a slab of plywood that had once been used as a desk. After getting laughed out of several used furniture shops for seeking a replacement for the cardboard dresser "in the $50 range," I came upon the cluttered Brighton Avenue basement shop of a man whose aging merchandise had stories to tell, although most would be telling it with their last gasp. Forty-five dollars took his top-of-the-line bureau, a workable, if unlovely, five-drawer, green painted model on rusted coaster wheels. Miraculously, he also gave me $10 in trade for the cardboard.

Meanwhile, one roommate had slapped seven pine boards together into a bookcase in the Vanderbilt woodshop, and the plywood was pressed back into service as a desk, straddling a filing cabinet and two wooden planks. The result, I think everyone would agree, is an elegantly understated appearance that could be right out of the pages of *Better Homes and Bomb Shelters*.

Next was learning the routine of keeping up an apartment. As my roommates soon discovered, the tasks of cleaning bathrooms, taking out trash, and mopping kitchen floors were quite new to me, but I soon learned these and other concepts, such as what it is about vacuums that nature abhors.

Then there was cooking. Gone, I discovered, were the sheltered days of youth, when only my ideas could be half-baked, when char-broiled was supposed to be a technique, not an outcome. Survival tactics initially demanded that I go with easy convenience recipes, but this got tiresome: my hamburger helper was asking time and a half for overtime. I have since worked on developing one or two staple gourmet items, such as Everything But the Kitchen Sink Chicken, a recipe based on the discovery that if you season chicken with just about everything within reach and bake in a

casserole for an hour, it will come out pretty good.

Invariably people wonder about the choice of Brookline over Cambridge, where people inevitably believe they live in the center of the universe—and for all I know they do. Brookline, at least my part of it, has the charms of a quiet suburb, but one can feel isolated from social and nightlife centers. That and some other considerations finally moved me to buy a car, a $300 used VW, which holds promise for being the first car towed from the medical area for purely aesthetic reasons. Because of Brookline's overnight parking ban, owning a car here raises certain sensitive ethical questions, such as whether killing is justified in trying to find a parking space to rent. Luckily, I found one—for $30 a month, a quarter of a mile away.

Finally, no article about apartment living would be complete without stressing the importance of having roommates who are simply outstanding human beings. Notwithstanding their threats to break my fingers as they watch me type this, I can only marvel at their keen sensitivity, warmth, and generosity. Yes, the right roommates can make apartment life truly civilized.

And the right words, I hope, can keep it that way. OK, fellas? □

Jamaica Plain

by Warren J. Manning '83

In the middle of my third year at HMS, I decided it was time to move out of Vanderbilt Hall. I was engaged to a student at the New England College of Optometry whom I had met while doing research at the Beth Israel Hospital, and we were looking for our home for the next few years.

As we didn't own a car, my wife and I would have to be at the mercy of the MBTA for transportation. That limited our search to Cambridge, Somerville, Brookline, Allston, Mission Hill, Back Bay, or Jamaica Plain. I put Jamaica Plain last on our list, as it was the area about which I knew the least. But on that beautiful fall day when we went walking in Jamaica Plain, we knew we had found where we wanted to live. Here was an area within easy walking distance of shopping and the Longwood medical area, yet it was residential, full of single-unit and double-decker homes, small apartment buildings, a large pond, lots of trees and greenery, and an occupationally and ethnically diverse group of residents.

We found a recently renovated two-bedroom apartment in a small building conveniently located by the MBTA Arborway line and the shopping areas. Rents in Jamaica Plain are quite reasonable: a nice two-bedroom apartment usually goes for $400-$500 per month. Our neighbors are friendly. Next door are Ralph, a post-doctorate at HMS, and Blanca, a middle-school teacher in Brighton; across the hall are

computer whizzes Joseph and Susan; upstairs are a few social workers and graduate students; and downstairs an engineer, computer programmer, and more graduate students. Often a few of us get together to have dinner, or just to stand in the hallway and "shoot the bull."

I decided that I would walk the 30 minutes to the Longwood area as frequently as possible. I soon cut my time by one-third, as I zipped down South Huntington, passing the Boston V.A. and the Boston Indian Council, then taking a short-cut through the Mission Hill apartment complex on Huntington Avenue. Coming home I usually took the subway (after all, it's free outbound—perfect for a student's budget!). Though living in J.P. makes me feel distant from HMS, I can easily hop in for a meeting or library session after dinner—and feel safe about it. Sue usually gets a monthly T-pass, as her school in the Back Bay is too far away for her to walk. It does seem safer for her to take the subway home in the evenings.

Sue and I had purposefully chosen a place to live which allowed pets. On our second trip to the nearby MSPCA we found a three-year-old Sheltie, housebroken and accustomed to being alone during the day. His name was Chief and he was corpulent, waddled, and seemed frightened of everything in sight. Chief walks us three times a day. We meet all the neighbors, pausing to chat and occasionally meeting other dogs.

In fact, Chief is more popular at Triple D's, the local tavern, than I am. One day, as I was walking down South Huntington, I suddenly realized Chief was gone. Hearing a big commotion in Triple D's, I walked inside, and there was Chief, being hugged and fed beer and pretzels by the local patrons.

Other local establishments include J.P. Licks, a homemade ice cream store which rivals any other. The ice cream is a delicate cross between the flavor and fullness of Steve's and the creaminess of The Ice Cream Factory.

Grocery shopping and the MBTA just don't mix. Fortunately, we can walk to the store in five minutes. Most everyone shops at Flanagan's, where the slogan is "Come as a customer, leave as a friend." Just a few minutes away in downtown J.P. we can find freshly baked breads, croissants, and pastries such as baklava in Today's Bread. Or we can drop by Blackbirds for a salad or sandwich, or fill up at La Española, a small Cuban restaurant with good food, large portions, and small prices. A macrobiotic restaurant, several fruit and vegetable markets, a hardware store, numerous antique/knick-knack shops, a health clinic, several banks, and a coffee house all help create a quaint small-town atmosphere.

When most people think of J.P., Jamaica Pond immediately comes to mind—a scenic area bordering on Brookline, complete with small-boating facilities, a paved running path, and plenty of trees and greenery. I frequently jog with the masses or just stroll around the pond with Sue, savoring the breeze which brushes across the water, and watching families picnicking along the side of the path.

Jamaica Plain isn't a perfect neighborhood. It's a residential part of a big city with big-city problems. I've heard of a few rare cases of suspected arson. Some neighbors have had their cars vandalized or stolen; a home on our street was recently burglarized. My wife and I *do* feel safe enough, though, to walk outside at night. The J.P. of today is not the same as the one our neighbors recall of 30 to 40 years ago, but nothing ever is as good as "the ol' days." The MBTA Arborway line doesn't always work as well as I'd like, or run as frequently as it should in the evening hours, but it is very convenient. We can hop on a train and easily get to Symphony Hall, the Museum of Fine Arts, or the Arboretum.

I really enjoy living here in Jamaica Plain. It's a neighborhood full of homes, families, and people whose lives are very different, and yet not so different, from my own. When I come home at night it's not to a dorm room or a student-flooded area, but to a real home. □

Roxbury

by Blanche Lowry '84

After agreeing to write about my experience as a student living in Roxbury, I realized that I had never thought of my home of the past two years as being in Roxbury. This is not to suggest that that factor would have changed my mind about moving here from Vanderbilt with my roommate, Shari Nethersole '83. After five and a half years of dorm life, I was ready for a change. I wish, however, to make clear that these thoughts should not be interpreted as a description of life in the heart of Roxbury.

My apartment building is located just south of Huntington Avenue, about an eight-minute walk from the medical area. A number of Harvard medical students live in the building; for the most part, they seem pleased with it. I particularly like the location

Mission Hill

by Steven Klein '83

I met my landlord, Kevin, on a beautiful late summer morning. He was sitting on his stoop flanked by what seemed to be the only flower garden on Mission Hill. I had lived in Allston, which was convenient but offered no neighborhood feeling, and in Arlington, and the spacious rooms in the apartment, as well as the laundry facilities available within the building. And the rent, which includes heat, is reasonable. The location is especially important to me on those cold winter mornings when I would prefer not to wait for a bus or take a long walk to get to school.

What have the past two years been like? I've enjoyed having more space, kitchen facilities, and privacy than in a dormitory. I am proud of my apartment and I enjoy having friends visit. But the neighborhood is noisy (which is to be expected when one lives in such close proximity to a large medical area), dirty, and unsafe: being cautious at all times is an absolute must.

I am able to overlook the unclean surroundings after being in their midst for a while. But some time ago, when I returned to my neighborhood after a summer spent in a suburb of Michigan, I was struck by the trash covering the sidewalks and streets. People allow their pets to defecate where they and others must walk.

Prior to moving here, I had heard that the neighborhood was not the safest. As the economy continued to plunge, the frequency of muggings on my street increased. I tend to take an alternate, slightly longer route home when walking to avoid the less safe section of the street. I have often felt that with the number of medical students living in the area, the medical area police should institute some measure to enhance safety, such as a shuttle service from area hospitals for students who are in the hospitals past dark. During the fall months, when daylight is shortest, there have been many evenings when I have literally run from the point where I enter my street to the front door of the apartment building. Within my home I feel safe.

As for the people of this neighborhood, most I don't know. But as I walk to and from my building, I see many who are perhaps socioeconomically distressed. I too as a medical student am economically distressed, but I see a light at the end of the tunnel. I often ask myself how many of these people see that light.

Some might ask why I haven't moved. I offer you this: as time has passed, the remainder of my time here has shrunk. And the herculean tasks of looking for another convenient, affordable place to live, and then moving, seemed unbearable. □

which was quiet and pretty, but too far from town. Now my roommate—who works for the Treasury Department—and I wanted to move closer to school and work, to friends and Boston's nightlife. For weeks we had scoured the papers with no luck. Everything was already taken, or too expensive, or had no parking nearby. Then I heard about Kevin from medical school friends who lived in the area. The neighborhood and the apartment he showed us were exactly what we wanted.

In days gone by, Mission Hill was a neighborhood of Irish Catholic working-class families. It was they who built the Mission Church, which is now mostly empty. Students, young professionals, and recent immigrants have since moved into the Hill's triple-decker houses, but a few of the old families remain, including Kevin and his wife, who are from the old country.

Kevin seems to know just about everyone and everything. Skills he once peddled—wiring, plumbing, carpentry—he now gives to those who need them. His wife gathers in our mail, watches my roommate's car, and lends us butter and sugar. In return, we plow the walk and help with the shopping.

Kevin and his friends watch over the Hill. They recognize faces, notice strange cars, and are aware when people move in or out. They know who belongs. Some of those who use the Hill don't belong: many from the medical area drive up, move the trash cans that mark "private" parking spaces, and park for the day.

Many of us who live here now are transients, here for a few months or years. As a result, a large part of Mission Hill has become very much like the fluid communities of the city—Allston, Brighton, Cambridge—where anonymity and heterogeneity can hinder relationships and a sense of community responsibility.

Mission Hill's attractions include the post office, the welfare office, a Hispanic grocery store, the American Legion post, a couple of Irish pubs, and the appealing scents from Mike's Donut Shop. Small mom-and-pop stores, necessities for the elderly, conveniences for the rest of us, are scattered over the Hill. Just five minutes away at Brigham Circle, where the Hill meets the hospitals, we can find whatever we need: banks, groceries, laundromats and cleaners, drugstores, pizza parlors, Chinese restaurants, tailors, and hardware stores.

I don't have a car, but the Green Line downtown and the medical area shuttle bus to Cambridge make the city accessible, albeit slowly. Relying on public transportation can be very inconvenient, especially on Sundays, so I often bicycle or walk.

I don't walk much around the base of the Hill, where a couple of teenagers once intimidated my roommate into handing over his wallet. And I never walk on the lower side of St. Alphonsus Street. But on the Hill itself, I feel relatively safe. Once I turn the corner off Tremont, I feel like I've reached home.

Living on Mission Hill, and sharing a place with someone whose work has nothing to do with medicine, brings me back to the realities that medicine sometimes forgets. For the past two years I have come home from the hospitals to a cozy neighborhood and an atmosphere of calm and sanity. Certainly Mission Hill has made a greater mark on me than I have on it. I'll never forget my stay here. □

The North End

by Hank (Enrico) Frissora '83

"Buon giorno, Dottore, come sta?" I am tackled, pinned to the pastry shelf, and force-fed two cannolis, a sfogliatelli, a zeppole, and espresso with sambucca before I can say, *"Multo bene."* The scene of this caloric assault is Caffe Roma; Anna M. (surrogate mother) and Eddy C. (octogenarian bouncer/drinking buddy) are the guilty.

About the cafe, customers look into the pastry cases and drool. Grandchildren are everywhere, boxing biscotti and polishing glass. I assume a seat in the corner by the elaborate window displays and sink into another pastry. I look across the triple-parked cars, deliverymen, and tourists of Hanover Street to the windows of my apartment two flights of brick above the Trio's Ravioli sign. This is home.

My love affair with the North End began several years ago when I started Introduction to Clinical Medicine at the MGH. With my *compare* Stedmanelli (alias Hans Stedman '83), I linked up with my godfather's dear friend Anna, who within one day found us a perfect apartment. She adopted us on the spot. It was not long before we knew the names, blood pressures, and heart rates of the whole Caffe Roma crew and countless neighborhood friends, storekeepers, and relatives. Within weeks we knew the neighborhood, and toured the back rooms and kitchens of shops, apartments, and restaurants practicing our new clinical skills, and fastening our belts progressively more liberally.

One of the last ethnic neighborhoods in Boston, the North End has seen tides of immigrants since colo-

nial times. The Italians have been the predominant wave of the 20th century; however, the tides are changing once again: now only about half the population is Italian.

I am the second-generation victim of hyper-Americanization. My grandparents, paternal from Italy, maternal from Armenia, settled in Watertown, Massachusetts, and in their desire to be American, brought up their children speaking only English. Luckily cuisines and some traditions survived. I remember sitting with my grandfather on Sundays, hearing stories from the old country and learning Italian phrases.

I am not the only one entitled to neighborhood identity. There is a view of the steeple of Old North Church from "Stedmanelli's" window, where in the 1700s his great uncle several times over, Fabyan Stedman, a mathematician, arranged the belfry so that extended chimes could be played.

I visit almost daily with Giulio. Stocky, graying, proud, Giulio is my *compare.* Our discussion is fueled by food and wine, Giulio's own vintage, there to "create the feeling" as we sit for hours in the back of his shop, Julio's. In the front window there is a pushcart wheel from the grinding wheel cart with which he began business on coming to America 15 years ago. He came from Abruzze, the mountain region east of Rome, from a town 20 miles from where my ancestors were born. Hence we are *paisans.*

Giulio speaks an English that is a literal translation of Italian, with all the flower and romance and emotion. Giulio, the philosopher, speaks of the "validation" of life, love, country, and generosity. He dreams of starting a clinic in our home, Abruzze, that I could oversee on monthly visits. And Giulio's dreams usually come true.

On Sundays, conclaves of Italian men convene at Julio's. Talk is heated and melodious. Periodically, they ask me to take out the blood-pressure cuff, and shirt sleeves go up across the room. I advise in my best broken Italian: "*No sale* (no salt), *no fumare* (no smoking), *il peso* (overweight), *esercizio* (exercise), *sta calmo* (be calm)." One man might pull me aside and explain he doesn't take his pressure pills because of impotence. A little reassurance and encouragement to see his doctor are all he needs.

Despite frequent reminders to our neighbors that we are only students, Stedmanelli and I have become a major clearinghouse for blood pressure checks, orthopedic complaints, psychiatric consultations, earaches, and polypains. It gives us a chance to be the type of doc who practices without needles or machines. Our "job," as we see it, is to refer to appropriate doctors and aid in compliance of their prescribed treatment. But mostly, we just listen.

One time Anna called me up to Eddy's apartment. Eddy, who is single and lives alone, looked ill. He had just had a severe dizzy spell. His pressure was 220/120. I borrowed a car and drove him up to the MGH. On arrival, I was not doctor or medical student, but worried "family" member.

The MGH, or the "Mass," as it is called, is a 10-minute walk or two-minute ambulance ride (I've gone for the ride twice) from the neighborhood, and serves as the community hospital for the North End. Since Stedmanelli and I frequently do rotations at the MGH, we often become the go-between, sort of family member/medical advocate, in the patient-care process. After evening ward rounds with the team, we've seen several neighbors or relatives scattered throughout the hospital: a confused elderly lady with a head laceration comes into the emergency room, and we recognize her as the woman with dementia who lives upstairs.

All roads may lead to Rome, but all conversations must drift to food, the Italian embodiment of life. The question I am most frequently asked outside the neighborhood is, "Where's the best place to eat in the North End?" To answer honestly: I have no idea. If I go to Sorrento's, I sit in the kitchen and, while watching Massimo and his son Paulo cook, I eat concoctions found nowhere on the menu.

When I stop by next door to say *ciao* to Flo and her sister Anne, I get two big hugs and kisses. They talk me into a glass of vino. Out comes some biscotti baked that morning. Then comes veal parmigiana that just happens to be in the oven, homemade gnocchis, roast peppers stuffed with mushrooms, mustard green calzones, rigotta pie, gelati, sambucca, espresso... Stuffed, I plead, "No more, thanks, I just ate." I'm sent out with a covered dish.

Cooking is a production, a dance, a religious experience. Excuse the bravado, but I must admit to having developed a sense about the kitchen. I've been known to do some pretty outrageous things with veal, artichokes, clams, or eggplant. Sted-

"Your blood pressure is fine, Tony, but I'm afraid your serum cannoli level is dangerously elevated."

Illustration by Hank Frissora

manelli, as well, is the accomplished pizza master. The act of feeding others strums primitive chords. And to shop is to visit friends. It's like rounds at the Mass. It takes hours. There are separate shops for fresh pasta, pizza dough, spices, ravioli, coffee, bread, cheese, meat, olives, fish, pastry, sausage, vino, vegetables, fruit, and braciole.

Like the Italian mamas who live all around me, I love to hang from the windows and take in the street: summer saints' festivals, the Saturday morning shopping crowd, the late night caffe crowd, the tourists with cameras and guidebooks and sunglasses. New Year's Eve with fireworks over the waterfront, large snowflakes and champagne corks flying between rooftops; looking from my window at the mamas looking out the windows down the street.

I have a painting in mind that hasn't yet made it onto canvas. As I sit at my drawing board looking onto Sorrento's, I witness two pigeons engaged in an elaborate mating ritual on the building's top edge. The second-floor kitchen is bustling to serve the lunch crowd. On the street below, a tough-looking 30-year-old in black leather, bent over, takes slow, calculated steps arm in arm with his grandmother. Twenty feet behind, a young mother, bent over, hand in hand with an exuberant two-year-old taking three wild steps to her one. I look back up at the pigeons. My neighborhood. □

Cambridge

by Jack Ringler '83

They asked me to tell you why I live in Cambridge. Do you want to know the real reason? The real reason is about six years old, has a very impish giggle, and was selling lemonade for 75 cents a dixie cup on Oxford Street on the day I set aside for apartment hunting three years ago. My soon-to-be apartment-mates and I were joyfully ripped off, and the rest is history.

I guess you want to know a tad more about Cambridge, right? Toward that end, I have assembled a composite "typical day" (that is, if you are willing to listen to someone who uses lemonade to decide where to live).

The Spa

I emerge from my little room at sunup. It takes 13 minutes to walk to the bus. I have left just enough time to grab a bagel at the Spa. The Oxford Spa is a real mom-and-pop store, owned and operated 365 days a year by two wonderful Greek immigrants and their son.

"Good morning, doctor," the smiling man says.

"Not quite yet," I reply.

"But soon, you be good doctor. We need good doctors. Have a nice day. Don't work too hard."

Don't work too hard. He is open 14 hours *every day*, closing early (2 P.M.) only on Christmas, so he can get to church, and I whine about the idea of internship.

"I won't work too hard, sir. See you later."

The Yard

Harvard Yard is most interesting in September. The daily passer-through has the unique opportunity to observe the annual transmogrification of high school seniors into Harvard freshmen. Timid teenagers chatting about summer vacation become jabbering intellectuals arguing about how to pronounce Dvořák. (Four years from now will I be cynical about medical students too?)

The Bus

Harvard operates a shuttle bus that runs between the Yard and Vanderbilt Hall. The 20-minute ride affords its bleary-eyed morning passengers the opportunity to get some last minute reading done:

(Diabetes Mellitus is an important cause of...) "Hi Carolyn!"

(Diabetes Mellitus is...) "Hey Seth, yeah they're choking again!"

(Diabetes M...) "No pitching; you gotta have pitching in September and you can't choke. The Sox always choke."

(Diab...) "Hobart! What's going on, buddy?"

Yep, I do some of my best reading on the shuttle.

Central Square

The bus makes its way down Massachusetts Avenue. Harvard Square "hip" gives way to Central Square "real." One of the few visibly racially integrated communities in the area, Central Square offers its several HMS residents a convenient, often reasonably priced living alternative. (The street lemonade goes for a quarter.) It is more urban, less urbane than Harvard Square, out of the shadow but well within reach of the giant campuses that sandwich it.

Kendall Square and MIT

I don't know anything about Kendall Square and MIT.

The River

Two daily trips across the Charles frame the day of the Cambridge Harvard medical student. The view is often spectacular, especially when the sun is rising over Beacon Hill. I think most of us who live in Cambridge like the fact that home is *here* and school is *there*. The view of Boston each morning and evening makes the commute all but painless.

The Point

Spending a great deal of time in the medical area can lead one to dichotomize the world into doctors and patients. There is a real risk of total immersion. There were nights in Vanderbilt Hall when I really thought I could hear synchronous page-turning. If

nothing else, Cambridge is diverse. Its residents cross paths with thousands of people doing thousands of different things. I am glad I live here because I am reminded daily by street musicians, storekeepers, preppies, Marxists, and six-year-old entrepreneurs with impish giggles to keep my medical pursuits in proper perspective. □

Somerville

by Ed Bromfield '83

Somerville. To the uninitiated, the name may suggest images of warmth and greenery, perhaps with a touch of British charm; on this basis a Swiss physician of my acquaintance, when planning a trip to Boston, chose the Somerville Holiday Inn from a long list of Boston-area hotels. Those with some local knowledge, on the other hand, think mainly of car thefts, suspicious fires, and the occasional "gangland slaying" that bring Somerville to media prominence. In reality, it is a large satellite city just north of Cambridge and Boston with a diversity belying easy generalizations, and with a variety of potential advantages for the HMS student.

Granted, my wife, Terry, and I live here now mainly because we lived here before I started medical school, and could not face the thought of moving even our then rather modest accumulation of possessions. For several reasons, though, we've never seriously questioned that decision. The rents are low, markedly less than those in most of Cambridge or Brookline, despite the recent failure to reinstate rent control. While the closely packed triple-deckers that make up much of the city are not all in the best of repair, many neighborhoods, such as Winter Hill, where we live, or West Somerville, near Tufts University, consist largely of once luxurious single-family dwellings that have been converted to up to six apartments. Condominiums are virtually nonexistent, and gentrification remains in an embryonic stage.

The composition and diversity of the population are a distinct plus. Though there is a smattering of young professionals and students, clustered mainly near the Cambridge border, the city is overwhelmingly blue-collar. There are older English and Irish families, first- and second-generation Italians and Greeks, and more recent arrivals from Portugal and Haiti. Somerville is, however, no melting pot, divided rather into many neighborhoods and "squares" (intersections at any angle of two or more streets), each with its own ethnic flavor.

This decentralization imparts a surprising small-town feeling to the most densely populated city in New England. By minimizing our contact with Somerville's two Star Markets and the new Assembly Square Mall, we've gotten to know the local butcher and hardware dealer. We say hello to almost all our neighbors, and would

not hesitate to borrow, say, a snow shovel from most of them.

Though far from a country environment, Somerville does exhibit some signs of nature beyond the nocturnal behavior of its pubescent youth. The bank of the Mystic River, for example, offers a view of water, with ducks and sailboats in season, as well as a unique collection of belly-up shopping carts, and some paths sufficiently off the road for fairly peaceful jogging or small-scale cross-country skiing.

A more characteristic and challenging outdoor activity, however, is driving. Despite my civic loyalty, I must admit that as a group we make even the average Boston motorist appear law-abiding; it took Terry and me about a week to learn to look both ways before responding when a light changes to green. The high car-to-driveway ratio necessitates on-street parking, a definite convenience for us, though our exercise of that right over five years has resulted in a new windshield, side window, and sideview mirror. Without statistics to support me, my sense is that such crimes may be more common here than elsewhere around Boston, but that the incidence of more serious property and personal crimes is not. Furthermore, some improvement may be coming with a growth in community spirit, spurred largely by '60s activists who have chosen to settle here, and manifested by such organizations as Somerville United Neighborhoods, the Somerville Women's Center, and the Somerville Community News. My involvement in these groups has been regrettably peripheral, but then my radical credentials are rather weak for those of a healthy 31-year-old who began college in 1969.

Probably the most serious disadvantage for the HMS student living in Somerville is distance from the Longwood area. Most of the city—including my neighborhood—is not in routine walking distance of the Harvard Square shuttle bus; during my first two years, fortunately, my wife worked near the Square and could drop me off. Since then I've managed to get to the medical area either by bicycling, which takes about 30 minutes, or by driving, which takes about 20. The latter has become totally infeasible, however, since the disappearance of subsidized parking and imposition by the City of Boston of a strict two-hour limit. If I were wealthy enough to pay daily rates in a garage, I would not be likely to live in Somerville to begin with.

Given the inadequacy of my oculovestibular reflexes to permit reading on the "T" (the only way of justifying the time commitment needed to use this notoriously unreliable and roundabout means of transportation), I have solved the distance problem mainly by doing rotations at more accessible institutions such as the MGH, Cambridge Hospital, and Mt. Auburn Hospital.

What Somerville lacks in four-star restaurants it makes up for in pizza parlors, present in perhaps the highest concentration anywhere in the Western Hemisphere. These range from the traditional to the organic—for example, Bel Canto in Union Square, where broccoli and walnuts may adorn a deep-dish whole-wheat torta ("Don't call it a pizza"). Ice cream is clearly in the big leagues, with Joey's in Teale Square and the original Steve's (now owned by Joey) in Davis Square. Somerville has a jazz club, the Willow, and a movie theater with a recently revamped format of rapidly changing double features à la Harvard Square Cinema. Films are also shown regularly at the well-renovated Central Library.

Somerville offers the essentials of life at an affordable price, and the diverse population provides the antithesis of dormitory living. Despite all these advantages, when my in-laws come up for graduation, I'll forget the local Holiday Inn, and suggest they stay at the Hyatt. □

Vanderbilt Hall

by Dorene O'Hara '83

When I first arrived at HMS, I moved into Vanderbilt Hall because "it was there." In a big, strange city (I'm from a small town), it seemed a reasonable and convenient place to live. So, I joined just about every other first-year student in the chaos that Labor Day weekend: triple-parked cars and trucks backed up traffic all the way down Avenue Louis Pasteur.

A group gathered in the tennis court at the center of the building to watch two students drag a huge couch up one set of stairs, get stuck, try another set, and finally in desperation hoist it through a window. My father huffed and puffed in the 100 degree heat to carry my color television up four flights of stairs: "What do you need this for, anyway? You're supposed to be studying." But as it turned out, the TV served an important function. My hallmates and I would later gather in my room to watch the Celtics games, the Super Bowl, and the Olympics. I was nominated for the award of "best TV."

At first the central phone in the lobby rang constantly. Day and night we heard, "John Doe, you have a phone call," blaring over the intercom. One day that first week about 20 of us walked two miles to the phone store, picked up phones and books, and trudged back. Then the phone company had the nerve to charge each of us an installation fee.

I went to Woolworth's for a few basics for my bare, desolate room: posters, curtains, a rug, broom and cleaning supplies, and potted plants. It wasn't easy to avoid bashing pedestrians with the end of my broom, but the perilous walk was worth it. The room became livable.

Amidst the activity of moving in, I began to get to know my classmates. Howard Grill, Eric Sorscher, and I sat in the hallway drinking warm Coke and swapping stories about home and college. In the evening a group of us sat outside on the tennis court, drank beer, and introduced ourselves.

The organized orientation included a huge cook-out on the tennis court, with loud rock music that could be heard from Huntington Avenue to the Beth Israel Hospital, and an elegant cocktail party in the Isabella Stewart Gardner Museum. I remember walking around the museum in awe, drink in hand, gazing at the courtyard brimming with tropical plants, and meeting our deans while looking at the paintings by Rubens and Rembrandt.

Vanderbilt differs in one major way from my dorm life in college: it is coed. On my floor we generally

agreed to designate one of the three hall bathrooms for the six women, and the other two for the 12 men. Aside from the occasional male too lazy to cart his dirty dishes down the hall (on at least one occasion I took a very long shower after hearing male voices in the vicinity of the sink), the arrangement worked out fine.

For the first few months, most of us ate almost exclusively in the Vanderbilt Hall cafeteria. It was convenient, and the food was good (but expensive). I would head downstairs a half hour before class to drink coffee and read the newspaper with new acquaintances across the breakfast table. A few of the guys organized a football betting pool, which I joined, being an undying fan. We'd discuss the odds at breakfast, and pass bets across the rows during lecture. I never won, though I came close once.

After awhile the numbers in the cafeteria dropped off. I continued to take most of my meals there; I was too lazy to cook, the dorm had no cooking facilities, and it was more fun to eat with others. Some students began cooking meals on hot plates in their rooms, setting up elaborate pantries and cooking areas. Occasionally we would go to one of the cheaper hospital cafeterias, nearby schools, or sub shops for dinner.

The single men found a double advantage to eating at the colleges down the street: the food was inexpensive, and they could meet female undergrads. The 11 A.M. Sunday mass and all-you-can-eat brunch at Emmanuel College became very popular. I went to the Emmanuel brunch several times with a few of the men. The girls loved seeing the doctors-to-be coming in, but I always had the feeling they were wondering who the heck I was, and whether I was "attached" to one of the men—and, if so, which one.

One of the fringe benefits of living in Vanderbilt Hall was that we were just across the street from the lecture halls. We could sleep late and still make it to class on time. Some students seemed to have it down to a science: up at 8:20, quick shower, dress, head downstairs to the cafeteria, grab coffee and a doughnut, then sprint to class, spilling coffee, but making it to the lecture hall by 8:32.

I liked being able to come back to the dorm to drop off my books or relax at lunch. While I was taking anatomy I would hurry back to try to get rid of the awful smell by taking a shower, although it never really worked. We just got used to the formaldehyde on each other while upperclassmen avoided us like the plague.

There were lots of fun things to do in Vanderbilt Hall, and not enough time to do them in. I tried to live as I did in college: study early in the morning and on weekends, and enjoy as many social and athletic activities as I could during the week. Whenever I

had a few quarters to lose, I'd go to the pool and video room to play asteroids or space invaders. A few of the other women and I joined the volleyball league and played right along with the men. We also had Saturday softball games against members of the Anatomy Department and the other classes. I was pitcher (probably because it was where I could do the least amount of damage). Once, after a particularly long succession of bouncing pitches, I turned to find the entire outfield lying down.

I was pleased to join a music society that gives two concerts a year; I had thought there would be little time to pursue my musical interests at HMS. We practiced weekly for the Christmas concert, the highlight of which was inviting the audience to join us in the Hallelujah Chorus.

As final exams neared, the atmosphere in Vanderbilt became quiet and tense. Tempers grew short. All outside activity came to a halt. Students closeted themselves in their rooms, emerging only to run down the hall and ask another frantic student a question. Meals in the cafeteria became a "college bowl" of obscure questions and answers, further heightening the tension. In the evenings we drank beer and ate cookies at the social hours held by the deans to help us get our exam worries into perspective, and then went back to work.

I found myself studying less effectively as a result of the growing tension. I started going to Countway or to other Harvard libraries. I wanted to talk and think about *anything* but medicine. Finally, by the evening before the test, I'd be so burned out from studying that I would give up completely. Other people were crammers. They'd put off much of the reading until the last minute, then stay up all night for a few days in a row, fueled by coffee and caffeine-filled "Enerjets."

Most students move out of Vanderbilt after their first year. They want to cook their meals in a real kitchen instead of over a hot plate. They want to see people who are not medical students. Some of them look for safer neighborhoods (the 24-hour guards at Vanderbilt—one of whom appeared as guest drummer in my class's second-year show—keep watch against local crime). Some look for peace and quiet. I have been awakened more often than I care to recall by ambulances, jackhammers, and accidentally pulled fire alarms.

I moved out in the second year to an apartment in Cambridge because I wanted to live in a bigger place with a few rooms (instead of one), to have a real kitchen, and to have some fun sharing a place with a classmate. But the next year I was back, having no time for cooking or hanging around in Cambridge, or even for spending time in my apartment when I was on call. I reverted to buying all my meals in the hospital or the dorm, just to save time for sleep.

Now, in my last year, I no longer live in the dorm. I still find myself there often, though, dropping by to say hello to classmates or the guards, to use the piano, or to have a meal. I'll run into long-lost friends who have been on rotation and catch up on the news—who has been accepted to what residency program, who has gotten married, who will be in Boston next year.

I'm sure Vanderbilt Hall will be as much a part of my memories of medical school as Building A or Amphitheatre C. Vanderbilt is where I made most of my close friends, where I ate my meals, where I met with other students at dances, happy hours, and volleyball games.

One of these days maybe I'll sneak back into my old room and put a brass plaque over the fireplace: Dorene O'Hara, HMS '83, lived here. □

Good Times, Good Deeds

The Evolution of Student Organizations

by Lisa Derman

It was at a meeting of the Boylston Medical Society in the early 1930s, as the story goes, that George (Barney) Crile introduced as speaker one Dr. Wycoff, an Englishman who had spent 30 years practicing in India. After delivering his paper, during which many students took copious notes, Wycoff went on to criticize both the faculty and the practice of medicine at Harvard Medical School. It was only then that the audience recognized its "visitor" as none other than fourth-year student J. Englebert Dunphy.

After the 1933 Aesculapian Club Show, a group of students, still in greasepaint, went out drinking and ended up in a barroom brawl. The next morning at rounds they successfully hid their hangovers and black eyes from the attending physician until Soma Weiss, Hersey Professor of Theory and Practice of Physic (later the faculty adviser for the Boylston Society), saw them and commented, "Doctor, I see we have an epidemic of conjunctivitis."

In the 1954 *Aesculapiad*, Nu Sigma Nu lists as its chief complaint "acute and chronic priapism and Korsakoff's psychosis." The Stork Club's nine presidents (all members were presidents) proclaim "No more high purpose than to relieve the cares of the day." And the Aesculapian Club protests that its motto—"I dressed the wound; God healed it"—is highly misleading, "for the aim of the outfit is NOT dressing wounds. In fact, the aim is usually quite poor."

Nowadays, instead of Argo Club lectures on time and space, students might attend a Sabbath dinner given by the Maimonides Medical Society, a Latin Fiesta held by the Boricua Health Organization, or a celebration in commemoration of Dr. Martin Luther King, Jr., sponsored by the Black Health Organization. Instead of sipping sherry in the afternoon with Phi Beta Pi members, they are likely to be invited to a discussion of wife abuse by the Hamilton-Hunt Association or a senior citizens' health-counseling session by Reach.

Rather than the half-dozen or so clubs, fraternities, and honor societies that flourished at HMS for decades, there are currently over 30 mostly new student organizations, each established for a different purpose. Several of them exist purely for recreation and enjoyment. The HMS Music Society sponsors two concerts each year, at which students and faculty perform any of a variety of styles of music. The HMS Outing Club, founded in 1832 by Oliver Wendell Holmes, fosters outdoor activities, and even rents a ski chalet in the White Mountains each winter.

Lacking the selectivity of the old fraternities and honor societies, which alone was enough to hold them together, the new groups center around some issue, topic, activity, or common characteristic.

The Vanderbilt Hall Photo Club provides a fully equipped darkroom and will lend a camera to members. And the Hobby Shop has set up a complete woodworking shop: any member of the medical area community who joins is trained on the safe use of power tools, and may use the equipment to construct whatever he or she wants. One popular project is building sets for the second-year show. Some students earn extra money by repairing tables and chairs for Vanderbilt Hall, which saves the school money as well.

A few student organizations reflect age-old interests. The Christian Medical Society meets weekly to discuss subjects ranging from a particular Bible passage to medical missions in Third World countries. Its other activities include a Thanksgiving dinner, a secret-Santa party, and a retreat to give people in the medical community a chance to discuss the relationship of their faith to medicine.

The Maimonides Medical Society provides a supportive framework for the religious, cultural, and social needs of the Jewish community in the medical area. It serves as an information source on the availability of religious services and kosher food. This year it has sponsored Sabbath dinners, Sunday brunches with speakers on various topics, a Sukkah, a traditional breaking of the fast after Yom Kippur, and a Chanukkah celebration of latkes and Israeli dancing.

The transition from the old fraternities and clubs to the new student organizations began in the 1960s. At that time, American youth began devoting attention to social problems, and Harvard medical students demonstrated growing concern for health-care issues abroad and health conditions affecting the poor—including then-illegal abortions—at home. As students across the nation lost interest in fraternities and clubs with purely social orientation and selective membership, enthusiasm for such groups decreased here as well, alumni from the classes of '63 to '66 recall. Women had been accepted at

HMS since 1945, but were accepted in much greater numbers by the '70s. Minorities began to assert their rights, and the school made a concerted effort to accept more students from various ethnic groups.

During this period, curricular and admissions policy changes—no doubt inspired in part by the changing social atmosphere—also affected student social organizations. With the institution of the pass/fail system and the abolishment of grades and class ranking, there were no longer criteria for selecting members of honor societies. Moreover, the combined effect of several other changes was to make the student body less of a cohesive unit. There were fewer labs and more lectures, thus cutting down on time for informal student-faculty and student-student interaction. Morning lectures for third-year students were abolished, so both third- and fourth-year students spent all their time in hospitals. There was never a time when they were all together.

As class size enlarged, a higher percentage of students lived outside of Vanderbilt and thus spent much less time together. And the student body itself gradually changed from a group of male students with similar backgrounds to a diverse group of men, women, minorities, and married and older students.

Under the combined weight of all these changes, the old fraternities and clubs gradually faded away. In their place, many new organizations have sprung up, and each year new ones arise and others die out.

Funds for all groups are divvied up by the Student Faculty Committee. The competition for shares of the pie ensures that no group without reasonably strong student interest will survive for long. For the most part, organizations are run by first- and second-year students, who hand on responsibility to the next class as they enter their clinical years. Each year second-year students complain of lack of interest on the part of the first-year students, who suddenly become much more active midway through the year.

Lacking the selectivity of the old fraternities and honor societies, which alone was enough glue to hold them together and give them an identity, the new groups center around some issue, topic, activity, or common characteristic. The Hamilton-Hunt Student Association, named after Dr. Alice Hamilton, the first female faculty member, and Harriet Kezia Hunt, who was admitted as a student only to have her classmates unanimously protest her admission and thus force her to withdraw, focuses on issues faced by women in medicine, both as health-care providers and as patients. This year the association has provided speakers and forums on women and alcoholism, wife abuse, eating disorders, childbirth, women and aging, and women in academic medicine, as well as sponsoring the Harvard chapter of the American Medical Women's Association. The advent of Hamilton-Hunt and AMWA reflects the current national trend of greater opportunities

Where Have All The Flowers Gone?

I can never remember whether it's the good or the bad that is oft interred with the bones. I imagine that it is both, and that the same goes for reminiscences. My Uncle George always used to say, "In my day we filed our teeth!" Of course we didn't (in fact, I had no Uncle George) but it is nice to think fondly about medical school years as by and large most alumni do. Since those who don't are the ones who never come back to reunions, they do little to diminish the LEGEND. And the present undergraduate knows enough never to ask how it was delivering babies on the district, the days "of the greatest obstetrician in his own impartial eye, the great God Irving of the BLI," as one Aesculapian show had it.

My class of 1940 was the next to last to graduate before the U.S. entered The War—World War II, that is. After that things never were the same and after Hiroshima and Nagasaki no one could go home again. No longer can we live by that cheery dictum of Corey Ford, "Leave your mind alone," but I keep whistling to myself, "Where have all the flowers gone?"

By flowers I refer to the structured social life, the fraternities and clubs of the medical school before the war and for a short time afterwards. There was Nu Sigma Nu, installed in 1913 by Harvey Cushing, its membership limited to 10 percent of each class. It had a club room somewhere in Vanderbilt for meetings and dinners with a prominent speaker, usually a *frater in facultate*. At least that's what we were told they did. Lancet Club, founded in 1902 as a chapter of Phi Rho Sigma, was another. It went the Harvard way and became a club. We said we offered the same opportunities for personal improvement that Nu Sig did; I don't believe either organization took things too hard—though possibly *they* did. But for the most part, the majority of the class could either take it or leave it alone. Both organizations became, so to speak, snarked by lack of defined purpose and the stain of elitism, and the Boojum got 'em in the late '60s. And as for guidance, we had our Tom Lanmans and Henry Jacksons and quizzical Worth Hale.

The Boylston and the Aesculapian fared better than the other clubs. The former did have a purpose; it was tightly organized and truly served an educational function. Membership carried a real responsibility of a formal presentation which if it was very well done might be published in the *New England Journal*. Regular bi-weekly attendance was expected, a faculty adviser participated actively—in my year it was Soma Weiss. (His influence lives on in the current Soma Weiss Award at the Undergraduate Assembly, at which each year since 1940 a dozen or so students have presented results of their research.) Even at that, the troubled late '60s and early '70s nearly did in the Boylston Society. The present Boylston, less tightly organized, is not only a survivor, its pendulum is in the ascendant (my, what a metaphor!). It is of, by, and for the students, and somehow or other has its own endowment.

for women and more attention to women's concerns, and the increased number of women at HMS—now about one-third of the student body.

The increased number of minority students at HMS has led to the establishment of four organizations devoted to ethnic groups, which function under the umbrella of the Third World Caucus. The most basic common purpose of the Black, Boricua (Puerto Rican), Chicano, and Native American health organizations is to increase the number of Third World students at HMS. In "Third World Students" (*HMAB*, September/ October 1974), Kenneth R. Bridges '76 summarized the importance of this goal in three points: 1) There is a national shortage of Third World physicians. Only increasing the number will rescue Third World patients from poor medical care. 2) Third World students can communicate better than others with members of their own groups (particularly non-English-speaking groups), and so help the medical process and break down doctor-patient cultural barriers. 3) HMS will be better if it is more representative of society.

It is not surprising, given these motivations, that the ethnic organizations are actively involved in recruitment, admissions, support, and counseling. Many send representatives to national conferences. Some arrange community efforts, such as the Black Health Organization's hypertension screening, Health Law Day, and seminars at the Harriet Tubman House. Others sponsor events—such as the Chicano Health Organization's Cinco de Mayo Symposium-Celebration and the Boricua Health Organization's Latin Fiesta—to provide others in the Harvard medical community with the view of health care from their perspective.

These cultural awareness events help ensure that the entire medical community is given access to these groups and that the existence of so many ethnic, sexual, and religious groups enriches rather than fragments the student body. Moreover, the organizations are not completely separate from one another: the Student Faculty Committee, which includes representatives from each organization, oversees them all. Some organizations sponsor others, and occasionally two organizations will join together for a special project. For example, the Native American Health Organization and the Hamilton-Hunt Association plan to co-sponsor a meeting with Dr. Joanna Clevenger, current president of the Association of American Indian Physicians.

The 20-odd other organizations concern interests acquired by students, rather than characteristics they were born with. Many of these groups embrace larger social issues that they see as important parts of medical education and the practice of medicine. Medicine and Society, an organization that sponsors speakers and films on social, political, and cultural aspects of medicine, this year has presented a panel discussion of stress in medical education, and speakers on Care of the Older Patient: Eastern and Western Approaches, Physician Involvement in Health Policy, Clinical Applications of Cultural Anthropology, and Staying Sane and Humane in Medical Training.

The Harvard branch of the American Medical Students Association (AMSA) has ambitious plans for next year: a community health fair, development of a university-wide health-related course guide, and initiation of stress-management workshops.

Medicine and Society and AMSA co-sponsor another organization, Reach, which provides health information to elders in the area. Reach proclaims: "It is very important for us, as medical students, to examine some of the prejudices and stereotypes our cul-

The Aesculapian Club has also survived, but largely as a graduate club for the Boston area doing what good deeds it can for the undergraduates and their social environment. The Aesculapian Club has a long tradition going back to the Thorndikes and the latter-day medical Brahmins. Its annual dinner and play had a tradition somewhere between a Dionysian rite and a trial of the faculty by lampoon. Its degree of elitism nearly did it in, also, and the increasing importance of the Second Year Show bids fair to eliminate the Fourth Year Gambols. With it will go fond memories of late spring evenings at the Longwood Cricket Club and anxious wives collecting sodden black-tied husbands along Hammond Street. Chauvinism has had its day!

Then there were splinter groups, the Stork Club for example—not the one in New York but a club with an obstetrical background, at least so they said. It was Ivy League drinking on an NCAA level. "Wet dinner" sounds different from "happy hour." It was.

—Gordon Scannell

The Stork Club, from the 1957 Aesculapiad. *Standing: Presidents Alexander, Remensnyder, McGeown, Leith. Prone: Presidents Wilkie, O'Connor, Cushing, Brunsting, Onken.*

The Aesculapian Club, from the 1954 Aesculapiad. *Front row: Taira, Green, Judd, Rashin, Matthews, Alper, Smith; Second row: Breer, Upson, Hitzrot, Vorenberg, Couch, Pugh; Third row: Evans, Ulrichs, Roth, Vine, Marcello.*

ture attaches to the aging process. Old does not equal sick. People do not cease to be people, or cease to be the same people, or become somehow inferior, just because they have lived a certain number of years." In accordance with this line of thought, about 20 students hold education and discussion programs on topics such as arthritis, low back pain, and blood pressure for elderly people in the community, do some screening (such as taking blood pressure), and refer people to hospitals.

The Harvard Public Interest Health Foundation (HPIHF) gives grants derived from membership dues to community-based projects for health education and promotion. Since its founding in 1981 it has given two grants. One went to the Gray Panthers of Greater Boston for a demonstration project to help nursing home residents

Letting Go

One year ago, in an issue of the *Bulletin* devoted to the subject of stress among physicians, the question was asked, "Does HMS pay enough attention to teaching students and alumni how to cope with stress?" It was an alumnus, Karl Singer '67, who asked that question, and it was other alumni who wrestled with memories, definitions, sources, and solutions in the pages of that issue. Part of the answer to Karl Singer's question lay in those responses. Part came six months later from a most surprising source—the students themselves.

This past fall Medicine and Society asked Thomas Gutheil '67 to discuss his observations on the stresses of medical education. Then Peter Slavin '84, Amy Ehrlich '85, and Chip Foley '85 started a general discussion by sharing their own thoughts on the subject. Slowly, painfully, the group—largely students from the first two years—articulated the unthinkable. In addition to being intoxicated with the medical environment, and awed at the prospect of becoming "Harvard" physicians, they were frightened, overwhelmed, and anxious. In short, they found they were human.

Excerpts from their comments follow:

—Most stressful to me right now is not what I have gone through, but what I fear about the future. There's an anticipatory stress about the second year, with getting to the hospitals, being exposed to people dying and suffering—not only seeing people suffer, but seeing people we can't help. Along with that fear goes an anxiety about not being able to live up to the most important goals I've set for myself in becoming whatever defines the good doctor. I guess you could argue that the anticipation is more difficult than the actual outcome.

—I've asked my classmates about this subject, and I've been struck by their worries of inadequacy. No one has brought up exams or the long hours; I think we've all learned how to do that sort of work successfully. There is instead the question: I don't know if I'm going to be able to be a doctor. We arrive here having been good at whatever we did, and now we're just at the beginning. We don't know anything about medicine. I have six years to go un-

Bill O'Connell

better understand their health needs. The other went to CommonHealth, a volunteer organization of health-care providers, to translate its newsletter, *Staying Alive,* into Spanish, and to increase its distribution. The newsletter informs consumers and providers about changes and proposed changes in public health services for Boston-area residents. HPIHF also presents forums to educate physicians and students about the unmet health needs of the community.

A more political organization is the Nuclear War Study Group, which teaches the medical community and politicians about the medical consequences of nuclear war. It has cosponsored a speaker training program with Physicians for Social Responsibility, and has also organized a trip to Washington, D.C., during which students and faculty met with U.S. senators and representatives.

A great deal has changed in the last two decades, but some aspects of student organizations endure, or have returned. The Boylston Society, the oldest continuous medical student society in the United States, still meets. Membership is now open and the presentation of papers is less formal than previously; talks are followed by lively discussion, accompanied by food and drink.

The newly established academic societies—which were initiated by Dean Tosteson and are not purely student-run—bring interested students and faculty together monthly for a social hour, presentation and discussion, and dinner. The Aesculpian Club still chooses fourth-year students to join its ranks. Alpha Omega Alpha, the honor society, has a chapter at HMS, but does not elect members presumably because there are no grades or class ranking. Of the fraternities, Phi Beta Pi (now merged with Theta Kappa Psi) continues to function, though it has no active chapter at HMS.

"It doesn't seem that students laugh as much as they used to," one alumnus commented wistfully to this writer. But of course medical students will always have good times and raucous parties. Though there are no more social club "wet dinners," students have "happy hours" on Friday evenings to celebrate the end of the week. The Vanderbilt Hall Social Committee still holds dances, and in addition has sponsored events such as Halloween costume party, a trip to Walden Pond, movies in Amphitheatre E. And then there's a celebration cruise on Boston Harbor after final examinations.

Plus ça change.... □

til there's a possibility of accomplishment.

—Several of us have made the point that maintaining relationships outside of school is important. But I think establishing close relationships with people *inside* the profession is equally important.

When the people you have relationships with outside the school see you for only a limited amount of time, they want to talk about what's going on in your lives together. I think you have to find people with whom to share the thoughts and feelings that can't be satisfied in the course of outside relationships. Our class has established a monthly pot luck dinner series that we hope will keep us together over the course of our third and fourth years. So far those monthly meetings have been very special.

—You don't have to be a psychiatrist to know that it's important to have healthy relationships with the people around you. It's also crucial to have a healthy estimation of what is good enough in your own work. You need to be able to measure for yourself that eight hours of sleep is a whole lot better than four. You have to find that peace within yourself about what is good enough, because if you're at peace with yourself, you're going to keep on learning. If you feel you've never done enough, the conflict can actually retard your progress. I feel a tremendous amount happier this year to have that balance in better perspective.

—I've had to make certain limitations on my career in order to function better in medicine by enjoying life outside it. Even though I enjoy surgery, for instance, I decided that the lifestyle just isn't worth it. It's important, and possible, to make such decisions. Our choices range from radiology or anesthesiology, where medicine becomes a job, all the way to surgery, where it can really be an obsession. Those sorts of choices make the pressures less severe.

Medical school gives us a privileged opportunity to encounter, in the environment, pressures which can result in stress. Regardless of what those pressures are, it is incumbent upon us, as future doctors, to learn how to deal with them. Our decisions here are not going to have that much effect on people's lives. Each of us has a chance not only to learn what is forced on us in the hospital, but also more about ourselves.

—Lisa W. Drew

Close Encounters of the

Introduction to Clinical Medicine: The First Day

Photographs by Jerry Berndt

On the first day of Introduction to Clinical Medicine this past January, I sat in the back of the Ether Dome at Massachusetts General Hospital with the other tutors looking at the 56 second-year students sitting in the rows in front of us. Two memories came clearly to mind. The first was that the seats in the Ether Dome are without doubt the most uncomfortable in the world. The second was how excited and anxious I had been exactly two years earlier in this same room.

ICM is taught to second-year students three days a week over most of the second semester. At the MGH the first month is devoted to physical diagnosis and history taking. Fourth-year students serve as tutors during this month and supervise teaching sessions in which the second-year students practice the physical exam on one another. These sessions complement lectures on the various aspects of physical diagnosis given by attending staff. The remainder of the course is divided into blocks designed to give the students experience in examining and writing up outpatients in the clinic and inpatients in medicine, surgery, and pediatrics. Attendings from the various departments serve as the instructors for these parts of the course.

The fourth-year tutors try to serve as something of a buffer to ease the transition for second-year students. It doesn't take an Osler to show how an otoscope is held, and it is perhaps less intimidating to be shown by a fellow student who isn't part of the grading process. There is also enhanced opportunity for second- and fourth-year students to discuss their enthusiasm and anxiety over approaching patient care for the first time.

On many levels ICM is an obvious turning point in a student's medical education. For many it is the first close exposure to seriously ill patients. Laying on of hands and the mechanical skills of physical exam are at first awkward, invasive, and uncomfortable. It can be disconcerting to realize that the methods which brought success over many years to a student in the classroom cannot serve a clerk on the wards the same way.

ICM, as my roommate puts it, is like going out on your first date—you have almost no idea of what it is you're supposed to do, but you want to look as if you've known it all along.

—Kevin J. Cullen '83

At left, Alan Goroll '72, director of ICM at the MGH, uses fourth-year tutor John Hupp in a demonstration of basic physical examination. In preparing the tutors for this day a week earlier, Goroll had observed, "The only transition more difficult in the course of medical education is becoming an intern." To the second-year students in the Ether Dome, he promised, "We are going to teach you to tolerate uncertainty." His practical advice: "Travel light. After you bend over there's that much less to pick up." Below, tutors hand out ICM camels to students in their groups.

Second Year

During a midday break, tutors took their new charges to the laundry room for their first white coats, and on whirlwind tours of the hospital. After early afternoon lectures, students and tutors got down to the task at hand—learning "in increments, a way not so different from other kinds of performing arts," as Goroll had put it a few hours earlier, "to touch someone."

The Test of Time

Two main questions inspired the following dialogs between three students and their alumni fathers: how has the medical school experience changed over the years, and what changes can be found in the ways soon-to-be physicians regarded their futures in past decades and the ways in which students now look ahead?

Each of the resulting pieces has taken a different shape. The contributors are Thomas Gabuzda '55 and Dana Gabuzda '83 (page 40); Albert Crum '57 and Rosa Crum '84 (page 42); and Evan Calkins '45 and Hugh Calkins '83, who respond below with a two-part article.

Evan Calkins

Any attempt to characterize life at Harvard Medical School 40 years ago must recognize the fundamental fact that the US was at war. For 33 uninterrupted months of intensive, intellectual work, 500 men were enclosed in barracks at Vanderbilt Hall, and in the laboratories, lecture halls, wards, and clinics of HMS and its affiliated hospitals. Most of us were in uniform—either the wool or cotton of Army privates or Navy blues. Summer vacations were abandoned and, with them, opportunities for a break in pace, or for individually designed educational experiences, or for research.

The militarization of Vanderbilt Hall and of certain aspects of student life brought reveille, an early morning march (always to the tune of "The Caissons Go Rolling Along"), and the colorful intervention of our two military leaders. The first, the memorable "Pussy Russy" Fairbanks, was open in his determination to "make Harvard the best damned medical school in the USA." We were determined, of course, to thwart this ambition. The second, Jerome Rosengard, showed us that one can be military *and* humane, a lesson which proved useful in later life.

Neither of these figures, nor the uniforms, nor the marching, nor a slight semblance of military discipline, nor (I confess with regret) the war that rocked the world, intruded to any serious degree on our lives or habits. We were interested in only two things: medicine and girls (now referred to as women). The girls we favored came, primarily, from Wellesley and the ranks of student nurses. Our parties were terrific, culminating frequently with "Starchy" Vaughan throwing a trash can down the stairway at Vanderbilt Hall. How these parties interdigitated with the disciplinary (?) efforts of "Pussy Russy" or Major Rosengard escapes my memory at present.

Those 33 months of living crowded together in Vanderbilt Hall (by means of double-decker bunks) were intense in every way. A confining, isolating experience, it also fostered a vigorous exchange of ideas and the forging of close, lifetime friendships.

Amenities which subsequently either appeared or reappeared, such as the tradition of inviting one's Service home for dinner at the end of the rotation, either had not been invented or were set aside. The concept of social interchange between students and the faculty was essentially nonexistent, due, no doubt, to gas rationing and shortage of time.

There were only two deans, Dean Burwell, whom one never saw, and Dean Worth Hale, a remarkably detached and dour figure whose impact consisted, primarily, of reassuring all of us that we were members of a lost generation of HMS students, and that none of us would possibly amount to anything. This did not disturb us.

Although the ranks of both full- and part-time faculty were depleted, and we missed the input of such figures as Walter Bauer and Pete Churchill, the faculty left behind worked overtime. One of our most enthusiastic and well-liked teachers, Baird Hastings, combined his medical school responsibilities with a several-day-per-week stint in Washington, returning by night train to give his lectures in the morning.

For the faculty the chief goal, during what must have been a trying time, was to adhere as closely as possible to "business as usual." The business was the preparation of the teachers, investigators, and physicians of the future. Amazingly, despite the limitations cited above, it emerged as a marvelous educational experience, based as it was on a solid commitment to the basic sciences, an intensive, varied clinical experience, the value of hard work, and the conviction that the most essential part of the process is that the student learn to find out for himself.

In the basic sciences, while we had the customary one-hour lectures (never more than two per day), the main emphasis was placed on the laboratories. Here, armed with drums which we learned to "smoke,"* we explored the mysteries of the muscle twitch under the watchful eye of Arturo Rosenbluth, and the effect of pharmacologic agents under the tutelage of Otto Krayer and his colleagues. We created nutritional deficiencies in mice, with Drs. Stare and McKibben, and learned our anatomy and pathology at the cadaver and microscope.

In retrospect, it is clear that the setting up of these experiments, especially in physiology, pharmacology, and

**A classic technique for recording physiological response by means of a pattern traced with a needle on a revolving paper-covered drum coated with soot.*

TIM CALKINS

KENDALL DUDLEY

nutrition, must have involved an enormous expenditure of time and money. We gained not only a solid understanding of basic human biology and pathology, as it was then known, but, much more important, an appreciation for the scientific method.

In the clinical disciplines, the same pattern prevailed. In the third year, the day was started with 8 A.M. lectures on various aspects of clinical medicine. These were straightforward and, alas, I have forgotten all of them! I do remember, vividly, our experiences with patients. The bulk of the third year was spent in the clinics; the fourth year in inpatient clerkships.

Electives were limited to roughly two months of the entire curriculum. No matter. If one had the good fortune to get to know Miss Dorothy (Dottie) Murphy, in the Dean's Office, one had something almost as good as electives, and possibly better — a chance to express, to a sympathetic ear, why one wanted to obtain certain rotations at certain hospitals, with a reasonable chance of obtaining at least some of the desired assignments.

I was fortunate to be assigned to physical diagnosis with Ben Massell at the Good Samaritan, obstetrics in Providence, a third-year clerkship with "Spike" Myers at the Brigham, fourth-year clerkships at the MGH for medicine (with Jake Lerman and Earle Chapman), and surgery with Leland McKittrick (and residents Gordon Scannell, Bill McDermott, and George Nardi), psychiatry at the MGH, and an additional two-month clerkship on the Peabody wards at the Boston City. Electives included endocrinology with Fuller Albright and a brief stint at the Haines with Louis Weinstein.

What made these experiences so rewarding? Certainly not that exercise which has since consumed innumerable faculty hours in many medical schools: a comprehensive, integrated curriculum. Except for a series of fine Saturday morning clinics organized by Herrman Blumgart for first-year students, and an occasional conference at the Brigham, we had no interdisciplinary clinics or teaching exercises.

No effort was made to coordinate the teaching of cardiovascular disease, for example, by the faculty in physiology, pharmacology, pathology, medicine, and surgery. (David Cheever assured us, solemnly, that with the onset of neurosurgery by Harvey Cushing, the realm of surgery had reached its ultimate limit. There was, of course, no possibility that surgery would ever reach the interstices of the heart.)

Little emphasis was placed on the need for complete coverage of anything. In my physical diagnosis course, teaching focused exclusively on the heart. In psychiatry, no attempt was made to describe or define the various psychiatric syndromes, diagnoses, or treatments. These limitations were inconsequential. As with all students, we learned much that was not specifically taught.

The essential quality of the teachers we valued and respected is that they were not only knowledgeable, but were interested in students and clearly enjoyed teaching. Who can forget the personal tutoring in interviewing techniques which Jake Finesinger provided? Who can forget the quality of Bill Castle's or Leland McKittrick's bedside teaching? Or the enthusiasm Bob Williams brought to the discussions at the Boylston Society, and the interest he exhibited in the potential careers of his students?

Throughout what was otherwise a remarkable and challenging educational experience, however, there was one problem which I believe many or all of us sensed, but rarely, if ever, spoke of. "We," our country and our generation, were at war, but we, HMS Class of '45, were not.

Although we were supposed to be preparing ourselves to serve our country and wanting to do so, we received no preparation for what we might logically be expected to do. Little time was spent in tropical medicine, public health, trauma, venereal diseases, or psychologic reactions to stress.

To my memory, the only occasion when any of our faculty members referred to our military futures was an unforgettable lecture by Colonel Walter Bauer, home on leave, stressing that it would be our responsibility, as Harvard men, to do just as good a job in our future military assignments as we would in civilian life.

I do not know the extent to which my concern was shared by my classmates. To me the trappings of military life emerged not as constructive preparation for a patriotic duty, but as a facade singularly unsuited to the high goals of medicine, or of true patriotism, and serving to isolate us further from the real world.

The late Marshall McLuhan pointed out that the message is the medium — that is, that one learns not so much from what is taught, but *how* it is taught. Referring to medical education, he pointed out that physicians who, as students, are taught primarily by the lecture method will lecture *at* their patients rather than listen to them.

In this respect, I believe that,

despite the lock-step design of our medical education, its basic principles were well suited to helping us become good, scientific physicians and teachers. As of this writing, the Class of '45 has produced one dean, at least six department chairmen (one at Harvard), numerous full professors, and excellent practicing physicians — but no military generals.

Whether the strange and somewhat warped social environment in which we obtained this education has played any significant role in molding for the ill our subsequent characters is difficult to say.

The past 40 years have brought major changes in medicine and society. We have seen the introduction and/or widespread application of such now-familiar tools and techniques as electron microscopy, immunoelectrophoresis, automated laboratory support, radioisotopes, CAT scans, cardiac monitoring, organ transplants, psychotropic drugs, and antibiotics.

With such advances has come the growing realization that the practice of medicine involves social and behavioral issues as well as an understanding of the biomedical sciences. Future physicians will be increasingly confronted with complex ethical questions as they attempt to apply technical advances to an aging population in an era of limited resources.

It would be interesting to find out whether the teaching environment of Harvard Medical School today is providing students with an opportunity to gain perspective on these aspects of medicine, as well as addressing, in its customary stellar fashion, business as usual: fundamental human biology and its application to clinical medicine. □

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Hugh Calkins

The Harvard Medical School experience certainly has changed a great deal since the "good old days" described by my father. These many differences never were more apparent than at the orientation program that greeted me upon arrival at HMS four years ago. It immediately became clear that rather than being part of a "lost generation," I was one of those fortunate and very privileged few who would have the responsibility of carrying on Walter B. Cannon's legacy, and who, as Dean Federman put it, were to undergo an experience that would "blow your mind."

In between receptions at the Isabella Stewart Gardner Museum, cocktail parties at Dean Tosteson's house, and baseball games at Fenway Park, we were introduced to our vast support structure, including advisors, faculty tutors, student tutors, and, of course, Carola Eisenberg, dean of student affairs.

As the academic year began, it was clear that these differences were merely the tip of the iceberg. While at times simply spending five days a week, eight hours a day, in Building C seemed far worse than being in any army, the U.S. was not at war, and this certainly was not a time for belt tightening. Dean Eisenberg invited all of us to dinner; coffee and cookies were provided between lectures, and at the medical society meetings sherry was served before dinner.

I'd often heard the phrase "the world is my oyster," but its meaning had never been so clear. Whether interested in research, primary care, occupational health, or computers, we could always find a course or an advisor and partial funding. For me, this meant a summer of research in a cardiovascular laboratory studying myoglobin release, and two months in Chomburi, Thailand, working in a refugee camp.

Vanderbilt Hall continues to play an important role in the forming of close friendships, but its days of glory are over. For most, the relative merits of dorm life diminish within a year or two; my persistence as a V.H. resident reflects the power of inertia and the value I place on convenience.

In contrast to the homogeneous group of men which formed my father's class, students' backgrounds vary tremendously, and the Class of '83 is 31 percent women. The social scene has clearly changed, with no fewer than five marriages among my classmates to date. But Wellesley still exists, nurses remain, and no one can deny the important role of Simmons College women at Happy Hour.

The issues of concern — aside from studying medicine or worrying about one's meager social existence — have been vivisection, nuclear war, MATEP (Medical Area Total Energy Plant), and, of course, tuition cost. Although the Dean's Office assured us that the $10,000 price tag was a *very* small fraction of the cost, on par with other private medical schools, those assurances provided little consolation when the term bill arrived. I am certain that many, myself included, wondered why they had turned down positions at good state schools, fully funded M.D.-Ph.D. programs, or merit scholarships at other private schools, for the privilege of a Harvard medical education. Was it the laboratory facilities? The great professors? The famous teaching hospitals? Or that Harvard name?

Clearly an M.D. degree is not

unique to this school, but the experience of a Harvard medical education is. Having now been through that experience, I would make that same decision again — only this time it would be a heck of a lot easier!

Despite these differences, my father and I have discovered that much has stood the test of time. The similarities extend far beyond the physical. Curriculum remains a mystery to many, and no one will question that the registrar, Ms. Koller, plays a vital role in rotation determination. Despite the very elaborate advisor system, upperclassmen continue to be the most important source of information. Not only can they tell you where to do clerkships, when to take the National Boards, and who the best Visits are, they also fill you in on which is the best inexpensive Italian restaurant in town, or where to pick apples in the fall.

During ward rotations, the days of doing routine CBCs and urinalyses by hand have ended, but students are still "scutboys," drawing blood, putting in IVs, and transporting patients.

The teachers continue to be excellent, showing interest in, and deriving enjoyment from, their students despite the demands of grant applications and the emphasis on research.

During the first year, Dan Goodenough shared with us his fascination with histology and his cosmic world view, Reinier Beeuwkes took us back to Harvey's discovery of circulation, Elio Raviola explained how the anatomy of the pelvic floor was like a "meat sandwich," and clinicians like Judah Folkman showed us how our newly acquired knowledge fit together in providing patient care.

When the clinical years arrived, teachers like Robert Masland, Gordon Scannell, Leslie Fang, and Gilbert Daniels taught us that medicine involves much more than physical findings, laboratory values, and differential diagnoses. They demonstrated the sensitivity and judgment needed to make difficult therapeutic and diagnostic decisions the consequences of which must be interpreted in terms of a particular patient's social environment.

In fact, the very underpinnings of the Harvard medical experience appear to be intact, with a genuine commitment to basic sciences and an intensive clinical experience heading the list.

Our approaches to such issues as ethics and financing of health care have been shaped not in the lecture hall (although an elective on medical ethics is available), but in the hospitals, where they are increasingly important in discussions of patient management.

Despite the absence of class rank or grades, hard work and sleepless nights continue to be an integral part of the experience. In addition to spending 40 hours a week in the lecture halls and laboratories, or 110 hours a week on the wards, we spent many of our remaining waking hours studying in the solitude of empty conference rooms, laboratories, or the plush elegance of the Kresge (School of Public Health) classrooms.

Two aspects of the medical school experience which I have found particularly important — the role of individuals, and a sense of humor — are among those that have stood the test of time. Geri, the admissions interview coordinator, has her own special way of making one feel at ease. Rodney, Bobby, and Ray, the Vanderbilt guards, always have stories to share as they learn students' names and observe their comings and goings; Gene, the floor janitor, is full of good cheer and good ideas.

Individuals took on a new magnitude of importance during the clinical years, when fellow students and patients have a large influence on one's existence. I had thought I knew my classmates fairly well, or at least as well as I cared to. But during clerkships, suddenly the name and face of my partner became vitally important to my survival of, or at least enjoyment of, the rotation.

I'll always remember the night Lora Fleming and I were manning the MGH Emergency Ward frontlines in minor surgery. It was 2 A.M. Saturday morning and, not wanting to miss anything, we both were awake. Our resident was asleep when a belligerent, disheveled gentleman arrived at the door bleeding from a large scalp laceration. Not wanting to disturb our resident, and confident of our knowledge, we set about our task. A coin toss determined that I would be the nurse and Lora the surgeon.

It soon became clear that our patient was roaring drunk and far from compliant. What happened next is unclear, but if someone had wandered into minor surgery ten minutes later, they would have found Lora and me singing "Brigadoon," the patient nearly asleep, and the wound being skillfully sutured.

I am certain each of my classmates has his or her own favorite patient. For me it was an 87-year-old Irish gent who fortunately presented to the MGH for his 29th admission when I was on call. During that sleepless night and over the next three weeks, he taught me more than merely the management of pulmonary edema, CHF, COPD, and diabetes. He taught me what being a physician is all about.

Graduation is approaching: the members of the Class of 1983 will soon be physicians. Have we been prepared? In the large sense, we need the perspective — which will probably always be heavily influenced by the examples set by our teachers — that will allow us to adjust and contribute to the rapidly changing medical world.

In the immediate sense, the preparation we need is the knowledge, stamina, and optimism to survive and hopefully enjoy 12 months of a grueling internship.

KENDALL DUDLEY

Thomas and Dana Gabuzda

Dana interviewed her father, then organized his answers under three main topics and responded with her own comments

Extra-Curricular Life

TG: Our social life centered almost entirely around Vanderbilt Hall. Practically all the students lived there, to my recollection, from the first year through the fourth. I imagine there is probably much more emphasis on diversity of lifestyle now. Back then you lived in a room, and your lifestyle was how you fixed up your room.

The only student societies were the social fraternities and the Boylston Club, which was exclusive. I belonged to Argo; I believe the other clubs were similar. The Argo suite at Vanderbilt was occupied by students who acted as custodians of the refrigerator. Members could drop down anytime, although I usually went only when there was a party. Sometimes several fraternities held parties on the same night, which lent a festive air to the dormitory—mostly from excessive drinking, I would say.

The single most unforgettable event in Vanderbilt Hall that I recall was the incident of the bonfire in the spring of 1954, right around exam time. We had all heard tales—told with a certain measure of pride—of riots at Vanderbilt Hall in previous years. Stories of shooting flaming arrows through open dormitory windows, of racing around the tennis court on motorcycles, were told with no sense of shame or repentance.

One evening we could sense the electricity in the air. We heard shouts up and down the dormitory corridors. The next thing I knew, there was a demonstration out on the tennis court. As students gathered at their windows to watch, some began to throw furniture, including Harvard chairs, out in the middle of the court. They then set the pile on fire. It grew into a huge bonfire that rose up practically to the height of the dormitory roof. Rather than being shocked or appalled, everybody seemed to be enjoying it. Soon fire hoses were taken out and turned on open dormitory windows.

Ultimately the police broke it up, and a heap of garbage was left in the tennis court. The next day, after it was cleaned up, we saw that the asphalt surface was ruined. Word got out that the dean was quite unhappy. The cost of repair was several thousand dollars. As far as I know, that was the last riot.

DG: Presumably this incident occurred in response to the pressure normally experienced around exam time. Our ways of venting energy these days are not on quite the same scale, perhaps because students move out of the dorm after the first year—and probably also as a reflection of the changing social milieu, including the integration of women into the class, the diversity of lifestyle, and the increasing popularity of taking time off before graduation. Forty-nine people from the original Class of '83 are not graduating this year. About 20 of them are in the M.D.-Ph.D. Program, and another 15 or 20 are involved in research. I also know of one classmate training for the Olympic Ski Team tryouts, and several who are traveling around the world.

Of the things we've done to keep our sanity, probably the most fun was our second-year show: *Medtime for Bonzo—or The Spy Who Came in with a Cold*, which featured, of course, plenty of harassment of deans and other well-respected figures. After having struggled through courses like anatomy and immunology, we derived a great deal of pleasure from a joke as simple-minded as "the ribs are great here" at Elio's (anatomical) Restaurant, or a surrealistic karate demonstration by a "killer lymphocyte."

Because students live in diverse locations after the first year, the social life no longer centers around Vanderbilt Hall. There are small parties or pot-luck dinners, and informal outings to bars or discos. There are no social fraternities, although there is a happy hour in Vanderbilt on Fridays which is quite popular among first- and second-year students. Other sources of common merriment are sports, the rented ski house in New Hampshire, and parties such as the Walter B. Cannon Ball held in Vanderbilt.

The Acceptance of Women

TG: There were about a dozen women in my class, and the class size began at 125, so that was about 10 percent. I don't know where they lived—probably in apartments. None were in Vanderbilt Hall. I never sensed among the men in the class any sense of resentment against the women. But, by the same token, there was no effort made to accommodate them in any way. Masculine orientations of lecture content or speech just went on their merry way. To my knowledge, not a single concession was made to how the women felt, and I never heard any of them express their feelings. Maybe they did among themselves, but since there were so few, most of us had little contact with them.

DG: Thirty-one percent of my classmates are women (51 women and 114 men). Women were first admitted to HMS in 1945. In 1968 the class was 12 percent women, and in 1978, 27 percent.

There is still a tendency for women to enter "traditional" specialties such as pediatrics, psychiatry, and OB-GYN, although a large number go into internal medicine, primary care, and family practice. Four or five each year choose surgery. Women also tend to enter clinical practice rather than research. This trend prompted the development of the Office for Academic Careers in 1981 to encourage women and minorities to become more involved in research.

My feeling is that sexism at HMS in general is no longer a major problem—at least for students. Minor problems still exist, and undoubtedly most of us can tell stories about individuals we have met who are not 100 percent enlightened. One of my residents had the habit of calling female medical students "toots" (short for "tootsie"), but he asked us so many times to report him to the Joint Committee on the Status of Women (JCSW) that I could hardly take him seriously. One Attending frequently called me "Doris Day," which is ridiculous for a number of reasons (Isn't she blond?). A resident told one of my friends that "ophthalmology is a good field for a *girl*."

Despite isolated incidents like these (which can usually be handled by direct confrontation), I find the prevailing attitude reasonably non-discriminatory. Lecturers, for example, often use pronouns with caution and usually avoid stereotypes. When problems do exist, the JCSW (established in 1973) is available to recommend a course of action. No doubt some difficulties remain, particularly in the post-graduate years. There are very few women in tenured faculty positions. Shared residency schedules, leaves of absence for pregnancy, and adequate day care at low cost are difficult to arrange. Most of us are also concerned about dual-career marriages, delayed child-bearing, and family/career dilemmas in general.

Looking Ahead

TG: Our choices coming out of medical school, as I recall, consisted of medicine, surgery, pediatrics, and pathology—and not much else. I think many students wondered whether to choose medicine or surgery right down to the time of residency applications. You had to put two years into the service or the NIH—but that decision came two or three years out of medical school, after residency. I would say most of my classmates chose the NIH.

I don't remember any of my friends using elective courses to orient themselves. I took a course in pediatric surgery, which was popular because we scrubbed with the great surgeon Robert Gross, and were treated as part of the team. I learned about ovarian tumors from Arthur Hertig, world renowned on that subject, and I took cardiology at the MGH, partly because it included exposure to Paul Dudley White. Most of us chose electives in a random way, to take what we liked and broaden our education.

Of the students I knew from my class, probably most went into medicine and then on to medical subspecialties. About one-quarter of the class clearly had an academic orientation. There was no family practice, and "general practitioner" meant that you had one year of training out of medical school and then practiced in a small town or a city. To be a GP at that time had almost negative prestige value, so there was a swing away from primary care.

I don't recall much discussion among students of the mechanics or economics of practice. Those considerations seemed far off, nothing to worry about. There was the general assumption that physicians did well financially. The tuition when I started was around $800 a year, and went up to $1,000 by the time I graduated. Very few of us, to my knowledge, had to go into debt.

DG: Many of us decide on subspecialties before we graduate. We are exposed to them throughout the four years, particularly in the second-year pathophysiology sequence (arranged in blocks, such as cardiology, renal, hematology) and during 10 months of elective time in the clinical years. Many of us use this elective time to explore career possibilities as well as broaden our medical knowledge—in part because some residency programs, such as ophthalmology, neurology, anesthesiology, and psychiatry, require application by October of the fourth year.

For some students, lifestyle and salary make certain subspecialties appealing. Others are disillusioned by certain aspects of academic medicine—the stresses and politics of the career ladder, the excessive and sometimes inappropriate use of medical technology, and the decreasing availability of grant support. Naturally there

is also a great deal of concern about the burden of student debt and the high cost of medical care.

Family practice and primary care have grown in popularity since the early 1970s, when residency training in those fields became more available. The top choices for the Class of '82 were: medicine 53, general surgery 21, family practice 13, pediatrics 11, primary care 9, psychiatry 8, ophthalmology 8, orthopedics 6, and OB-GYN 5.

I confess to being one of the minority who chose a subspecialty rather early on. Like most, I entered medical school with no earthly idea of what I would eventually pursue, outside of a general notion that I would like to stay in academics. I became interested in neurology by the end of my first year, mainly because I was fascinated by neuroscience and had a number of excellent teachers in that area. I worked in a few laboratories and took several electives in basic neuroscience and clinical neurology. Last fall I applied for a neurology residency, and in general I anticipate a career that will emphasize research.

How are others arriving at career decisions? For the most part, according to Curtis Prout, chairman of the Internship Advisory Commitee, through an assessment of their interests and personalities and consideration of the work and practice in a given field. Role models, among both faculty and house staff, are also important factors. Is money an important consideration? For most, I think not. I can think of only a few students who plan to go exclusively into private practice. The overwhelming majority, I believe, expect to maintain some academic affiliation, and perhaps 10 to 15 percent are considering full-time research. □

Thomas Gabuzda is on the faculty of Jefferson Medical College, and is chief of the Department of Hematology at Lankenau Hospital in Philadelphia.

JIM KALLET

Albert and Rosa Crum

The Crums were interviewed together by the Bulletin

HMAB: Let's start with your observations about the more obvious differences in your medical school experiences.

RC: Going through it right now, I wonder what it was like back in my father's day. We take so many of the changes for granted—such as the information explosion and advances in technology. It's hard to imagine what medical education was like a generation ago.

One of the best changes at HMS has been the growing flexibility in being able to take time off, to open up our lives a little. After I graduated from Barnard, I worked there as part of the faculty for one year. I applied to medical schools then, and came here the following year.

AC: People didn't do that often when I was at HMS. Everybody was close to the same age. I came straight to medical school after college, and graduated when I was 25. In senior year there were some flexible programs, such as the one at Guys Hospital in London, and there was an opportunity to do some research in the tutorial program, but everybody tried to finish with their class.

I think now there is also more diversity in the student body, and more opportunity for minorities and underprivileged students. In my class there were only two minority students, and two or three women. That's a big difference.

RC: A crucial difference. The availability of medical education to both groups is an asset to everyone, not just minority group members. As for me, a woman with a Third-World minority background, it's an important factor in being able to be here in medical school.

HMAB: Has your experience at HMS been influenced by the fact that you're a woman?

RC: I've had no problems as a woman; it's been an excellent experience. I know I'll eventually have to deal with the questions of how to fit marriage and children into my professional life—questions such as how to manage a two-career family, when to have children, what if I want to make a commitment to someone who's going to be in a different place. But that isn't my primary focus at this point. I see other women making it all work; I think success requires real planning ahead.

HMAB: Back to the information explosion and the advances in technology: how do they specifically affect your medical education?

RC: That's a difficult question to answer, because we take it so for granted. We assume that we'll have lab results, for example, with the speed that a computerized system offers. In radiology, I learned to interpret results of ultra-sound machines and CAT Scans. I've seen arthroscopy performed once; it was amazing.

HMAB: When we conceived of doing this piece, Perry Culver (director of the Alumni Association) wondered if students now have the same degree of personal contact with faculty members they once had. Would you like to comment on your opportunities to relate on a one-to-one basis with established physicians and researchers?

AC: When I was a medical student there was an outstanding tutorial program. A few members of each class—five to 10 percent of the upper half—could participate, with the approval of the dean. You could pick someone you wanted to work with on a research project for four months during the senior year. We had almost daily contact on a one-to-one level with outstanding professors; I worked with Walter Leiver and Edmund Klein at the MGH.

One of the best changes has been the growing flexibility in being able to take time off, to open up our lives a little.

We used to meet with Louis Dexter, head of the program, in small groups to report the progress of our research, and he would have us over to his house. We also got to know Walter Bauer. It was an interesting and intimate time—a period of closeness which has always stayed in my mind.

RC: Students still arrange to do research on a one-to-one basis. They might use a month between clerkships, as I am now, or take a year off to do so. I'm spending this March in Judah Folkman's lab, helping with his research on tumor angiogenesis. I'd been interested in working with him, and arranged to do so myself. I've applied for non-clinical elective credit for the work, but I'm also doing it to help me with decisions about the future. I'm in my third year, and I haven't decided what direction to take after medical school. I may take time off to do more research, partially in order to help me make those decisions.

I think such arrangements are much more up to the individual than in the tutorial program of my father's day. The curriculum in general is more flexible, probably in part because there are no longer grades other than pass, fail, and honors—and evaluations with the clerkships. Some of the classes are just pass/fail.

AC: We had grades, but weren't too aware of them. I remember George Packer Berry saying in his introductory lecture, "You're here because we want you to be here. We don't want to flunk you out. We want you to know the excitement of medicine." I think that went pretty deep. There was so much self-motivation on the part of the students that we always wanted to do well. I suppose there were a few who made it a stressful thing. Most just wanted to excel.

HMAB: That brings up a related issue: the question of the premed syndrome. Were either of you aware of much competition in college?

RC: The Barnard program was quite rigorous. I think the way people handled it depended on attitude. Reactions varied from class to class, from individual to individual, and partly depended on how professors and advisors reacted. Several of my friends and I used to study and work together. Some students were more antagonistic than cooperative; I think there will always be some like that.

AC: When I was in college there were still many veterans around from World War II, and only a limited number of medical schools. It was very, very competitive.

HMAB: That's interesting. Those concerned about the premed syndrome seem to assume the competitiveness is a fairly recent phenomenon.

AC: I went to a wonderful, small school in southern California called the University of Redlands. My professors there made the courses as rigorous as possible; they wanted to establish a

good background for a student coming back east.

Close to 90 percent of the students at HMS came from the real prestige colleges. Many of them had gone to preparatory school. It was a big change for me, but I looked upon it as a challenge. I wanted to learn. The atmosphere was encouraging, supportive, not uncomfortable at all. I really felt a sincere closeness with the place.

HMAB: Did you know in college that you wanted to be a physician?

AC: Oh, yes. I decided when I was 16. I remember it very vividly. I was riding my bicycle to school, and I suddenly knew that medicine was going to be it. I even remember the exact part of the block.

HMAB: What set it off?

AC: I was close to a few physicians in my home town, and I'd been doing some reading. The idea was in abeyance. But that particular day it all came together. I guess there has to be a certain moment when the issues in making a decision—for me they were concerns about the economic and transitional factors—are put into perspective. I had been very athletic in high school, and hadn't studied too much. After that day, I *really* started taking books home. My grades went up. My teachers said, "Albert, you've changed!"

RC: My decision was more gradual, and took place in college. I don't remember a specific time or day, or what block I was on riding my bike. I was thinking over a lot of alternatives. I was very involved in anthropology—I still am. The summer after my first year of college I worked in an emergency ward, and I really enjoyed it. I had always loved science. At the beginning of my sophomore year I decided to become a physician.

HMAB: What differences have you found in the way you looked, and now look, at your professional futures?

AC: Rosa was saying she doesn't know what specialty she plans to go into. I tell her to be patient, take your time. I liked psychiatry so much in medical school—it came so easily, and I looked forward to the classes so much—that I was almost guilty about doing something I so much enjoyed. I didn't then recognize that it was something I would want to do for my professional life.

At that time young physicians were still being called up for the service; we all registered right after internship. I interned in medicine at Columbia University Division/Bellevue, and then did biochemical research in the neurosciences at Creedmoor Institute for Psychobiological Studies, which counted as a year of psychiatric residency. At that point the Air Force made me chief of the Neuropsychiatric Division, Continental Air Command Headquarters.

Although I didn't have much clinical experience at the time, the Air Force was determined to fill that position with someone from an Ivy League school, as the position involved interviewing candidates for all the military academies. Partly because of that firsthand clinical experience, I then made an unequivocal commitment to the field of psychiatry.

RC: I'm getting exposure to so many people in different fields, and I enjoy it all. I haven't taken some of the major clerkships yet; right now I'm just being exposed to what the specialties are like. It's not an easy decision.

HMAB: Do you feel that any of the big issues out there, such as financing of health care, are influencing your approach to your future? Do you worry, for instance, about finding the residency of your choice?

RC: It's hard to think on a day-to-day basis about the larger scheme of things. That kind of awareness is more in the back of my mind. Medical school is very absorbing. It's important, but not an immediate concern, to keep the outside world in mind.

HMAB: With any profession there are sets of doubts that come with the territory. Do you think those that accompany medicine have shifted over the years?

AC: I imagine new developments could be looked upon with anxiety by those who want to finish learning, get it over with, but I welcome them. I have faced a very interesting situation in psychiatry, where there have been major changes in terms of taking into account the physiological, biochemical, and neurological factors. This year I've found time to go back to New York University for a Masters degree in the neurosciences. It has been a delightful and interesting experience.

RC: I think doubt is a personal experience which exists in every generation, but varies from person to person. Right now I'm facing choices about my future; I'm not sure I'd call them doubts.

AC: I think Harvard tries to choose students who love knowledge and medicine in all its complexities—students who see complex situations as fascinating rather than as sources of anxiety. Rosa has such an attitude. She's a very strong person.

HMAB: How did you react when she decided to go to medical school?

AC: I was very pleased, because I knew how happy I had been. I've been glad to have that kind of joy, and certainly wanted to share it. □

Albert Crum has a private psychiatric practice in Brooklyn, New York.

Mail, By George!

Letters Home, 1882-1886

by George H. Washburn

It has been one century, half the life of Harvard Medical School, since the Washburns of Constantinople, Turkey, received and saved weekly letters from their son George as he made his way through HMS. "A lonely young man with parents far away," as his son Alfred later characterized him, George wrote home about everything from meeting and studying with such luminaries as Oliver Wendell Holmes and Henry Pickering Bowditch, to attending "swell" events which required evening costume, to accounts of Boston weather ("slush up above my ankles"), to the familiar request, "I need some more money, by the way, as I have used up all my credit."

Born and brought up in Constantinople, where his father was president of Robert College, George graduated from Amherst in 1882 and entered HMS that fall. In his third year he evinced a keen interest in clinical medicine by applying for the position of house officer at Boston City Hospital at a time when hospital work was required only of fourth-year students. After six months on the Ophthalmic Service, he reapplied to spend a year and a half on the Medical Service, a term that continued six months after he received his M.D. in June of 1886.

In 1962 George's son Alfred H. Washburn '21 put together a selection of excerpts from George's letters for HMS alumni "who might be interested and amused" by the "vivid picture of the life of the medical student in 1882-1887." That manuscript, along with additional letters discovered recently, reached the Bulletin *this past Bicentennial year through Alfred's son Thomas C. Alexander-Washburn '57.*

George H. Washburn went on to develop a successful practice in obstetrics and gynecology in Boston and became professor of OB-GYN at Tufts Medical School and senior physician at the Free Hospital for Women.

Alfred Washburn wrote of his father: "He combined great skill as a surgeon with such warmth and hearty charm of personality that his patients felt better almost as soon as he entered the room. Amongst his colleagues he was also known for his delicious sense of humor and his ability as a storyteller. His career brought him the admiration of his colleagues, the loyalty and affection of many successive classes of medical students, and a host of grateful patients. To all he handed on something of his own contagious enthusiasm for the life of a good physician."

The First Two Years

Farewell to Oliver Wendell Holmes

December 3, 1882. Last Tuesday Dr. Holmes gave his farewell address and our class presented him a loving cup. I was the one appointed to present it with a few words. The whole thing will probably be published in the Med. & Surg. Journal, of which I will send you a copy. Our class were first admitted to the lecture room, then the doors were opened to all. They came in with a rush and in about half a minute every seat & all the standing room was occupied. A number of professors and doctors had chairs brought in for them on the stage. As Dr. Holmes came in everyone rose and there was prolonged applause. As soon as it ceased I presented the cup.

December 11, 1882. I send you by this mail a copy of the Med. and Surg. Journal containing Dr. Holmes' farewell lecture and an account of the presentation. If you wish a complete account you can supply my name for "a member of the first class."

From the *Boston Medical and Surgical Journal*, December 7, 1882:

"The applause having subsided, a member of the first-year's class came forward bearing a very handsome Loving Cup in silver, which he presented to Dr. Holmes on behalf of his classmates in the following words: —

" 'It is with deep regret that we come to this farewell. We had hoped, when we entered upon our course, to be permitted to listen to your lectures throughout the year. But we are thankful that we have enjoyed that privilege at all.

" 'Desiring to express our regard in some form more tangible than mere words, we beg you to accept this loving cup. As you may look upon it we hope you will sometimes remember us, as we shall always remember you.

" 'We bid you farewell in the words inscribed on the cup, "Love bless thee, joy crown thee, God speed thy career.' "

Alfred H. Washburn '21, who first put his father's letters in manuscript form, was director of the Child Research Council at the University of Colorado Medical Center until his retirement in 1960. He died in 1972. His son Thomas C. Alexander-Washburn '57 directs the Chronic Pain Management Program at the Spalding Rehabilitation Center in Denver.

"Dr. Holmes was evidently much moved, and expressed his thanks in a few brief words."

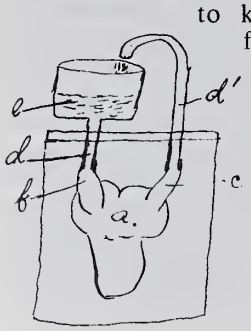
Medical Education

December 3, 1882. There were a couple of very interesting operations at the hospital. One man had tracheotomy performed on him. He took no ether at all, but I am told that it is not a painful operation. Another man had a tumor growing in his lower lip and right against the front part of the lower jaw.... A large part of the lip had to be removed, then the flesh had to be drawn up from round about to make a new lip for the man. It was quite a long operation but the man looked tolerably well when it was finished.

The man who had his tongue cut out came in the other day so that we could see how he was getting on. He could talk after a fashion though his articulation was not as clear as it might have been.

December 11, 1882. The operations Saturday were none of them of special interest except that they brought in the man who had his chin cut off the previous week. The whole had nearly healed and his mouth had assumed an almost normal shape. The man who had his tongue cut off some three or four weeks ago came in to see if the wire could be removed from his jaw. He has been out of the hospital for some time (about a week) and can talk quite well.

December 18, 1882. We had a very interesting experiment in Physiology the other day showing the independent character of the tissues of the heart. A frog's heart had been cut out and suspended in a small glass vessel as represented in the figure. (a) = frog's heart (b) = Vena cava (vein) (c) = Aorta (artery) (d,d') = glass tubes (e) = solution of salt (½%) and blood. The salt to keep the blood from coagulating. Though the heart was thus entirely separated from the frog it kept on pulsating, driving the blood up the tube d' whence it would fall in the receiver & be returned to the heart. The heart kept beating for over a day.



George H. Washburn as a young man

George H. Washburn with his father and son George E. Washburn

January 7, 1883. Dr. Bowditch has told us today of a plan he wishes to have carried out. All in the class who can do so, he wishes to have take up some subject in physiology which is too extensive to be fully treated in the regular lectures, but which has importance and interest enough to deserve some notice. He suggested a large number of subjects for us to choose from. He has already prepared references for each subject and these were placed in envelopes to be given to those who chose the subject. The essay is to be carefully prepared, to take 10 minutes for delivery, and two are to be read every Monday morning. Half an hour is to be given to each essay, ten minutes to reading it and the remainder of the time to general discussion by the class.

Then if the professor sees that anything of importance has been omitted he will supply it.

April 22, 1883. In his last lecture on Toxicology, Dr. Wood told us of a curious circumstance that had come to his notice. Not long ago a child died with all the symptoms of Arsenic poisoning. He had been playing with some paints and the suspicion was raised that the paints contained Arsenic and that he had put them in his mouth. The paints were analysed and found to contain not a particle of poison. Further investigation showed that he had mixed the paints on the glazed paper cover of a pamphlet and wet the brush in his mouth. The paper cover on analysis yielded a large amount of Arsenic and it was that which had caused the child's death. The pamphlet was the annual report of the "Society for the Prevention of Cruelty to Children."

May 7, 1883. Today we have listened to our last lecture in anatomy for this year. The rest of the time before the examination we have given us to review the subject and get ready for the final effort. I dread these examinations very much indeed. I wish they were all over with!

Social Life

December 3, 1882. Towards evening the rain turned to snow and Thanksgiving dawned clear. The sound of the merry sleigh bells were soon heard and, judging from the number present at church, I guess a good many thought the sleighing preferable. The service was at the Methodist Church and the minister gave us a very good sermon. I am happy to state that he did not use so much lung power as usual so that by sitting on the rearmost seat I was able to stay through the service.

December 11, 1882. I went to Sunday school yesterday afternoon and in the evening I called on the Grinnells and found them out. I then called on the Fosters and had a very nice call. We sang some sacred pieces while a lady calling on Miss F. played the accompaniment.

December 18, 1882. The past week has seen a good deal of dissipation. Tuesday afternoon I went out to No. Woburn. I found them all at home, and well except Katy who had a cold.

Wednesday morning dawned chilly and cloudy. After breakfast Uncle C. asked me if I would not like to go over and see some chemical works not far from them. I said yes, and we drove over. We went in the carriage as he has no sleigh.... It was very interesting but rather cold wandering about the different sheds for there is a different building for each product.

May 6, 1884. The past week has been one of change, and rumors of change. At the boarding house they coolly changed the dinner hour from night to noon. Of course I did not like that, so I looked about for some other place....

Last Saturday afternoon I went down to Salem. I found Dr. Johnson and one of the boys working in the garden.... After supper a patient came in to have a slight surgical operation performed. I was asked in to give a little assistance. I spent the whole evening there, returning on the ten o'clock train.

On the Dangers of Wellesley

May 6, 1884. In the afternnon I went out to see the Curruths. On the way I stopped at Mrs. Baker's, but she was at church. Miss Jones was at the house. She was taken sick and has had to take a short vacation. I shall discourage any friends of mine from going to Wellesley. It is a regular manufactury of invalids. I have heard, this past year, of quite a number who have left in a broken down condition.

Third and Fourth Years

The Examination for the Position of House Officer

November 1884. Twelve men presented themselves, six from the fourth and six from our class. We all gathered in a room at the hospital. A dozen cases had been picked out of the wards, and the numbers of the beds written on cards. We each drew a card. Then we had an hour allowed us to go to the patient, get his history, make our examination, and write out our diagnosis with the reasons for it.

I was unfortunate and got hold of a tough case. I found out three things that were the matter with the man but the fourth I overlooked. I was unlucky in getting the hardest case given out. The time also was not long enough.

After the hour was up we went around to the large reception room of the establishment. We had to go in two installments.... Seven of the staff of doctors were sitting about the room, as far apart as they could get. There was an empty chair in front of each. We distributed ourselves about and the examiners first looked at our letters of application for admission to the examination. They gleaned our name, and what they could of our character from that, then proceeded to question us. The secretary sat at a table in the center of the room. When 10 minutes had passed he struck a bell, and we each moved to the next man, until the seven subjects had been struggled with.

I found some questions very hard, and some whose answers I was not acquainted with; but on the whole the examination was a very fair one. I am satisfied of one thing, however, I stand no chance of being admitted to this hospital.

November 1884. Four men from the advanced class and one from our class were successful. I was the sixth man—just missed it.

January 4, 1885. A telegram was handed to me which proved to be from City Hospital, asking me to come there at once. After dinner I went over to see what the trouble was. Dr. Rowe, the superintendent, informed me that one of the House Officers had resigned. This created a vacancy. They had concluded that the best way to fill it was to offer the place to me, as I had stood next in order at the last examinations.

He also made a few complimentary remarks as to my examination, and let me know that I had tied for fifth position. The only reason that the place was given to the other man was that he had studied a year more than I had.

I went around to see Dr. Shattuck [either George, Jr., or Frederick]. On learning the facts in the case he also recommends that I accept the position. In fact every one to whom I have spoken about it says I ought to take it.

A Day in the Life of a House Officer

February 23, 1885. To begin with the waking in the morning, I generally get up at 25 minutes past seven. This allows me just time enough to get in to breakfast at the last minute. Breakfast comes at half past seven and we are allowed just 15 minutes' grace to reach the dining room. After breakfast, which generally consists of steak or chops or eggs or fish, and rolls, coffee, milk and oatmeal, I generally spend about ten minutes in the medical consulting room looking at the morning paper. Then I go down to the laboratory to perform the analyses of as many specimens as are sent down from the wards. Now there is generally a little work in the way of copying records after having made my ophthalmic visits. The ophthalmic patients do not number more than a dozen.

At half past nine Dr. Edes makes his morning visit. I have to accompany him round. This visit usually takes an hour and a half. Then three days in the week Dr. Wadsworth, the ophthalmic surgeon, makes his visit about this time. The days he does not come I go to the outpatient clinic and Thursdays I go to the Med. School.

We dine at one o'clock. Our meals are very fair. We always have a roast and vegetables and fish or ham or something of the kind. Then comes pie, pudding, and ice cream with cake—I forgot to mention the first course which is soup. After dinner I take a short rest, if possible. Then a couple of hours are usually spent attending lectures at the Medical School. Then there are batteries to be given—new patients to be seen, the older ones who have any change in symptoms have to be reexamined, the afternoon ophthalmic visit to be made. Before all this is accomplished supper time comes, at six o'clock.

I finish up my duties about the wards after supper. At eight o'clock the lights are put out and the patients turn in for the night. Now comes the time to make up the records for the day. All occurrences about the patients have to be made note of, any change of symptoms or anything of importance or interest. Also, all the medicines that have been prescribed during the day have to be copied into the record book.

The medicines are prescribed by the visiting physician and senior house officer in "order books" which belong to each ward. I have to copy them from these order books. The most convenient time for me to do this is at the end of the day. So about nine or ten o'clock I go round to the wards and sit down for a few minutes in each place in the vestibule outside of the ward, and copy the medicines. It is rather a nuisance but is made bearable by the fact that some of the night nurses are quite agreeable. I often have a little chat with them. Sometimes they give me a little luncheon clandestinely, either a cup of chocolate or a glass of milk and slice of cake, or something of that kind. This is contrary to regulations but very acceptable!

I also try to get some time in the evening for study. There are many incidental duties which come up, of course, and have to be attended to. Fridays there is frequently some ophthalmic operation at which I have to assist. Then the house officers get opportunities to talk over cases, and when some important surgical operation is to be performed we generally have the opportunity to witness it.

Occasionally, too, we have a less pleasant duty—that of taking part in an autopsy and getting records of it.

On the Ophthalmic Service

February 10, 1885. A very interesting case came in yesterday. It is unusual for the quiet of the Ophthalmic Service to be interrupted by an emergency case. Most of our cases are children having eye troubles which we treat mostly with tonics, good diet and regular life. About dusk yesterday I was called and told that a man had just come in who had sustained some injury to his eye. I found him with a wet compress on his eye, which I removed. He had stooped down suddenly, and a piece of broken glass had been driven into his eye, making a very bad cut. I put on an ice compress, a few small pieces of ice wrapped in a little absorbent cotton, to keep him comfortable till Dr. Wadsworth came.

On his arrival he said there was no hope for the eye, and advised its removal. So we at once etherized the man and took the eye out. Today the man has scarcely any pain, and this afternoon he got up and dressed himself!

Decisions, Decisions

March 10, 1885. You ask me as to my plans. I don't know what they will be.... It would be a valuable experience to spend a longer time in the hospital if I could secure a position such as I would like. The only trouble would be as to the time that this would consume. I should have to remain a year and a half.

May 1885. Next week Thursday come the examinations for admission to the hospital. There are a large number of applicants. Many of them are strong candidates. I have had very little time for special work for these examinations. As a result I feel a little dubious as to my success in getting on again. If I get a position that will lay out my programme quite clearly. In case of failure my plans will be without form or shape.

May 1885. In my last letter I believe I stopped at the supper on the day of the examinations. After the staff had compared marks, and made up averages, and decided on the ones to appoint, they most of them came to the dining room.

There was quite a spread, oysters, raw and scalloped; turkey, boned, and cranberry jelly; lobster and chicken salads; ice cream; tutti-fruti; cakes, strawberries, oranges and bananas.

After this collation the staff departed, and the house officers adjourned to the surgical consulting room. Here we could, without disturbing the patients, indulge in college songs, etc. At a late hour we betook ourselves to bed.

The staff would not announce the appointments till the names had gone to the trustees.... Three o'clock found me at Dr. Draper's door.... He informed me that I was successful in obtaining an appointment. He went on

to say that he was happy to congratulate me further on having passed the best examination of any of the contestants. In fact I had received the highest mark possible!...

I have my choice of positions and the question now is what I had better choose. As I don't expect to make a specialty of surgery I am inclined to take a medical service. This will give me three months of minor surgery in the outpatient department. I shall ask advice from several persons before making a decision.

On the Medical Service

Summer 1885. I forgot to say that Monday last was the hardest day we have had in the outpatient department. There were 115 patients, four of whom had to have plaster of Paris apparatus applied. Starting in before nine we did not finish our work till quarter of four. We begged a glass of milk and a cracker from one of the wards, to sustain us.

Summer 1885. I have been unable to do much of anything except attend to my work. I enjoy it, however, and some of it is quite exciting. The ambulance brought in a man, the other day, onto whom a bag of wool weighing 350 lb. fell from a fourth story window. He was pretty badly shaken up, but did not have very many bones broken. He is doing very well. Another night a woman was brought in whose husband threw her out of the window. A broken arm and bruised head are the results—doing well! And so they come, with one thing or another.

I am glad to see that the cholera has not reached Constantinople. They are having quite a time with smallpox up in Canada.

A Taste of Private Practice

Summer 1885. A young doctor, a friend of mine, wished to go off on a vacation. He did not want to close his office so asked me to come over here and look after his practice during his absence. He has not much practice, this being his first year, so I am not burdened with much extra work. I have an opportunity to see how it seems to wait patiently for patients. I came in here last Saturday. Mornings, of course, are spent at the hospital. I try to stay in the office afternoons and evenings. I pass the time reading medicine and a novel or two, with Shakespeare as an occasional companion.

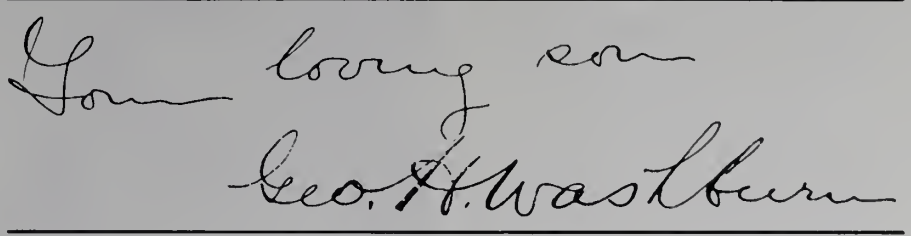
Treatment for Influenza

Autumn 1885. I know that unasked advice is rarely regarded as worth much, but when you have an influenza in the head again I think you will find great relief by the use of a solution of cocaine. Get a four per cent solution of cocaine. Take a camel's hair pencil, or something of the kind, and apply a few drops, a dozen or so, of the cocaine solution to the inside of the nose, reaching up as far as convenient. Cocaine has become very cheap now. A year ago it was selling for a *dollar* a grain, now it retails at seven and a half *cents* a grain.

Looking Ahead

September 1885. I have finished all my examinations at the Medical School. All that I have to do now is to write a paper on some surgical topic and hand in a thesis. I can't take my degree, however, until next June. We are not allowed to take our diplomas till we have been in the hospital nine months, and degrees are given only in June.

Autumn 1886. I took dinner with Dr. Shattuck the other day. He asked me my plans. I told him I had no definite ones as to a place to settle. He recommended strongly that I open an office here in the city. I talked the matter over with some of my other friends



Social Life

April 1885. I spent some time in arranging to have a vacation of a week. First I had to get permission of Dr. Edes, the Visiting Physician. He had to write a note to the trustees. This I had to present to the committee on vacations. It was approved there. Then it had to receive the concurrence of the Superintendent of the Hospital. Lastly, I had to get some one to take my place while away.

Winter 1885-86. Last Wednesday night I went to a very nice orchestral concert—quite a swell affair—had to wear evening costume.... Tuesday evening I went to a reception at Mrs. Coolidges' in honor of Miss Thursby. The thing was rather stupid for me until the music began, for I did not know anybody. I was introduced to a number of people, of course, but they were not very exciting. They had a number of musicians there—Wulf, Fries, Campanari, etc.—who played beautifully. Then Miss Thursby sang a number of times. She has a voice of great power and expression. I enjoyed her singing very much.

here. They all gave me the same advice. They said it would probably be very slow work at first, but would pay better in the end. They intimated that they would throw work my way.

Autumn 1886. A couple of days ago Dr. Doe told me that one of the large practitioners had said he wished a man to assist him in his office work every day; also to help in operations, etc.... I should open an office for myself and outside of office hours with Dr. Baker my time would be my own, to practice for myself. I should receive a regular salary for the work I did for him. He would leave patients with me if he was away; he would send some patients to me.... The whole thing, of course, depends on whether he is satisfied with my work and methods. It seems to me a remarkably good opening if I succeed in my part of it—an offer not secured every day, and one not to be thrown away without a trial. As it stands now it seems best that I should take up with the offer, and open an office here in January.

Fighting the Common "Cold"

The search for warmth in the Longwood medical area

by Robert Coles

Occasionally the word "cold" is used in a spiritual sense, to indicate an insistently successful medical population of those who have no apparent inclination to ask the important, soul-stirring questions one would think fitting to men and women taking on every day that most fundamental of all matters, the question of life itself.

Illustration By Katherine Mahoney

Year after year I hear some Harvard Medical School students use the word "cold" to characterize aspects of their intellectual and residential stay in the Longwood Avenue area. Occasionally they use the word in an aesthetic reaction to the almost uninterrupted expanse of hospitals, laboratories, dormitories, buildings crammed with administrative offices or classrooms. Such critics judge the lawn in front of the world-famous marble buildings as insufficient; they render a similar appraisal of the small, crowded Coop bookstore, the restaurants and fast-food stores squeezed into hospitals and office buildings.

Occasionally the reference is to the academic orientation: lots of clinic corridors and research facilities and scientific instruction, but relatively little encouragement to read history (even history of science), literature (even novels and poems by or about doctors and their work), the arts (even the photography that might be used as an accompaniment, say, to courses in public health or social medicine). Occasionally the word is used in a spiritual sense, to indicate a medical population of insistently successful doctors, nurses, research workers, laboratory technicians, and students who have no apparent time or inclination to stop and ask important, soul-stirring questions one would think congenial and fitting to men and women taking on every day that most fundamental of all matters, the question of life itself: how to preserve it, how to learn its secrets, if not significance.

If only things were as they are "across the river": plenty of good record stores, all sorts of interesting if not exotic restaurants, movie houses featuring a seemingly endless parade of provocative films, many of them foreign. If only one might browse in bookstores along Longwood or Brookline Avenues, as one does in Harvard Square, where one can buy dozens of magazines and newspapers: *Le Monde, The Times* of London or *The Irish Times*, Rio de Janeiro's *Jornal do Brasil*, or Frankfurt's *Die Welt*. Only recently was our own *The New York Times* readily available in front of Vanderbilt Hall—and in those street boxes, speaking of the cold, the impersonal.

Recently, one student whom I'd come to know when he was a Harvard undergraduate called the teaching he received in his first year at HMS "cold." I asked why. He told me about mimeographed lectures and course

summaries. "I don't even have to go to classes at all," he said, adding, "There's little contact with the professors." He observed a similar detachment in himself and his fellow students: "I feel we're becoming narrower and robot-like. We memorize long lists, we forget them, we memorize other lists. We wait until the third year—and then, I hear, it's another type of rat-race, trying to keep up with new lists, of 'signs and symptoms!' "

A passing moment of self-doubt, perhaps; a student exaggerating in order to deal with the weight of a new and demanding educational experience, maybe. Still, the words have a familiar ring, as do these, written for me when I decided to write this piece: "I find the place stifling. I don't read much anymore—only textbooks or notes on physiology or biochemistry. They wheel in a patient every week or so, and we're supposed to be encouraged: the light at the end of the tunnel. But my [college] roommate's brother is in the fourth year, and he has the same complaints: he doesn't even read the newspapers much, just glances at them, or the magazines—except when he's on an easy elective, and when that month comes, he still doesn't read much, because he's out of the habit of reading, really reading, after the last few years. And he majored in English!"

In my Literature and Medicine course at HMS, the students frankly acknowledge (and often enough complain about) the constraining pressures which make difficult the reading of novels and poems. Even the novel *Arrowsmith*, which so obviously lends itself to medical school study, is described as "long" by some—though, I hasten to add, others read it with great enthusiasm. As for George Eliot's *Middlemarch*—in which a doctor's ideals and aspirations are carefully scrutinized and connected in their changing character to the kind of life he lives—even my most avid students tell me to be "careful" about which weeks to choose for the reading of such a novel, so expansive and densely reflective: during much of the academic year there is simply not enough time for an examination of Dr. Lydgate and the altruism of his eager medical youth, the increasing cynicism of his later medical career. Such students tell me that "leisure" is the problem—not enough of it for those novels.

On a bad day I hear, again, the word "cold": the subtleties of literary and philosophic analysis must give way to "cold professional realism." That phrase, used by one student several years ago as we had lunch at Vanderbilt Hall, keeps coming back to me as I listen to Harvard medical students talk about their lives. The resort to the word "cold" at that moment was interesting, and I think of some general significance: "cold" as in "sober," a compelling and necessary part of an individual's obligations; and "cold" as in the actual, the everyday, the *here*, the given tasks that cannot be ignored. In the latter sense, the word "cold" becomes less pejorative, maybe not so at all; in that sense, the word signifies a reasonable response to certain necessary, sometimes lasting, circumstances.

By no means is the above logic meant to justify conditions which any number of medical students—out of the depths of their hearts, sometimes!—condemn strenuously when they use the word "cold." I've been trying for years at HMS to teach the prose and poetry of William Carlos Williams, the essays and novels of Walker Percy, the short stories of Flannery O'Connor, and, with some classes or independent tutorials (even in the clinical years!), those novels *Arrowsmith* and *Middlemarch*. I've done so not, I hope and pray, for merely decorative or entertaining reasons: a bit of literary polish, or a spell of relaxation and diversion. Those writers address big issues, indeed—the ironies and ambiguities and complexities of this life; and they do so with a boldness and an attentiveness that make us stop and pay heed. Their insistence upon self-criticism is especially important in medical education. Whether one prefers biblical language ("pride" or "vanity"), the language of a Victorian novelist such as George Eliot ("unreflecting egoism"), or that of 20th-century psychoanalysis (the vicissitudes of "narcissism"), the problem is the same, and not only the doctor's.

In a secular, materialist society, Science is king (and with it Medicine as Applied Science). The same faith holds for all: a faith in man's growing technological competence as the only hope in face of the waiting, eternal, mysterious darkness of the universe. After twenty years of talking to Americans of all sorts, I see that faith in no likely prospect of modification, for all the fads and shifts in opinion

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which seem to characterize our lives.

"We all die," one old, quite religious black tenant farmer, from the Mississippi Delta town of Itta Bena, told me in 1965. He added, "I believe in God, but I also believe in staying here as long as possible, and the only one who can help me do that, when I get in trouble, is the doctor, and that's why I'm glad there's one white doctor in the state of Mississippi who's ready to help out us colored folks, and God bless him, and God be with him, and I'll tell you he's the nearest one to God I know hereabouts."

At the time I was particularly interested in the question of civil rights, but that comment, as my wife observed even then, has a more general (cultural) significance. If we all struggle with self-importance, the jeopardy to ourselves of an attentively responsive, even gullible, public is fairly obvious. So, all the more reason to keep in mind the shrewd observations of writers such as William Carlos Williams, or Walker Percy, or Flannery O'Connor, who remind us of the worst possible coldness, that within us, that of the self inflated, the self all too sure of its own value and authority, the self so preoccupied with its might and workings and destiny that others become utterly insignificant, mere objects in a sad, dis-edifying game of mirrors—our own immodest, imperious efforts endlessly to enhance ourselves.

That phenomenon is not by any means confined to our medical centers. If there are doctors and aspiring doctors who are cold out of the arrogance the profession not rarely visits upon its practitioners, there are others in (or headed toward) other professions who show no lack of swagger and conceit. The complaints made about HMS's coldness are also voiced about Harvard College and its Graduate School of Arts and Sciences. Cambridge undergraduates (even faculty) speak of "anonymity"; complain of an impersonal, competitive, cliquish atmosphere; use that word "cold" again and again to express criticism or disappointment with respect to the academic life they have come to know.

As with HMS, some Harvard College students concentrate on buildings, on the physical and social side of a particular neighborhood: "This is a big place, all those buildings; and nearby is a crowded, noisy city, people pushing, all day long pushing. You take your life in your hands crossing Massachusetts Avenue. You could drop dead on the street, even in the Yard, and people would keep going—to a class, or to meet someone in some phony high-priced restaurant with a foreign name.... And if you're lucky, on a weekend night, you can find a movie in the Square that's in English! Everyone is on the make—more with their minds than their bodies; that's another trouble! Maybe it's just that I'm from a small town in Texas that I say these things; but I think this place is as tough as can be, and cold, real cold, especially to someone like me who comes in cold to start with—not part of the 'scene.' "

Concerned about his own generalizations—do they reflect any statistical truth?—this student assents, finally, that he is not necessarily representative of anyone. But neither are those who call the medical area "cold." Not that groups of students haven't assembled, in both parts of the university, to express collective criticism or discontent of one kind or another. For years I've heard Harvard College premedical students share complaints of the fierceness of rivalry in classes and laboratories, the lack of respect they feel certain teachers (and, alas, fellow students) accord them. Recently I heard Dr. Judah Folkman of Children's Hospital describe his similar impression at a meeting of a Harvard premed society of the grim, dreary time the students felt themselves having.

One wonders, hearing such comments stated with such earnest apprehension (verging, at times, toward despair), how it is that some of those same students manage to do such wonderful things at college—work on the newspaper, take part in sports, in hobbies, in valuable efforts on behalf of others. Oh, of course, they are building up their records in preparation for the scrutiny of 10 (or is it 20?) admissions committees. Still, they have managed to generate their own kind of enthusiasm and achievement—heat and light to mitigate the coldness and darkness they claim to feel and see.

Each year I also hear Harvard medical students express their real joy at being where they are, and not only because they are in a school of top reputation. They mention (as why shouldn't they?) many quite wonderful opportunities that come with being where they are: nearness to Boston's Museum of Fine Arts, to the Gardner

Each year I hear Harvard medical students express their real joy at being where they are, and not only because they are in a school of top reputation. They mention nearness to Boston's Museum of Fine Arts, to the Gardner Museum, to the Boston Symphony Orchestra, to book stores and record stores and art galleries beyond the Fenway...

Museum, to the Boston Symphony Orchestra, to book stores and record stores and art galleries beyond the Fenway on Newbury Street and Boylston Street, and to the Charles River, with its banks for jogging, its view, its sailing possibilities. I hear similar enthusiasm expressed in Cambridge by Harvard College students.

A Harvard undergraduate once told me that no matter how awful some of his experiences were, he couldn't "go wrong." I was perplexed at his use of that phrase. He explained: "I'm 20, and I'm here, and I'm free to go to a lecture, a concert, a museum show, a hockey game—I'm free to try lots of things out. In a couple of years I'll be trying *one* thing out, and then it'll be another game, and it'll be scary for a while, I'm sure."

No doubt about it, at medical school there is, indeed, only "one thing" on everyone's agenda: to learn to be an able, knowing physician, no mean or easy task, these days, given the complex, demanding nature of the profession. Perhaps, at times, medical school seems "cold" when, in fact, it is the "scary" nature of mastering the enormity of medical knowledge that is at issue—cold and clammy fear.

To be sure, there is plenty of room for improvement, as there is in any part, one suspects, of any of America's colleges and universities. I wish all we physician-teachers could be more decent, generous, lively—less egoistic, pompous, self-important, and not least, warm rather than cold. So with the medical curriculum: one wishes its content and manner of exposition to inspire professional competence, absolutely, but also what the Book of Common Prayer calls a loving-kindness. But Lord, we have to be careful and stop and think: I believe we all have known the terrible irony of the humanities—wonderful poetry and novels and plays—being taught in such a way that "the letter, not the spirit" rules the day. Those who teach literature and the social sciences have not been proven immune to narrowness, meanness, indifference to students, pettiness, insolence, *amour propre*. Literature, too, can become part of an excuse for an arctic atmosphere.

Meanwhile, speaking of ironies, every day in the Longwood Avenue area hundreds of men, women, and children come in fear to one or another building, sick, hurt, their lives in jeopardy. They want and need help, and they get that help. The hurt and ailing are attended—if necessary, given beds, fed, treated until (all hope and pray) they can leave, well or on the way to becoming well. There are failures—of judgment, of knowledge and competence, or even of common courtesy and civility. Still, the overall effort must surely qualify as quite literally "humanistic," a decent and honorable struggle—indeed, a warm-hearted one—on behalf of the very lives of human beings, even as college courses in literature and the arts, at their best, try to convey what human beings (whose nature it is to try to comprehend and evoke the meaning of life) can manage to say or paint or sing and compose.

One suspects that thousands of those human beings, called for a while patients, have over the years had good reason to record the warmth of their feelings toward this or that part of Harvard Medical School, even as students, too, witness the intensity of human emotion generated on those clinical corridors. And speaking of those students, I remember (I hope I never forget) Bob Ely (HMS '83), who died in 1982 while working at Lambaréné, in the middle of the African continent. He was learning to practice medicine at the hospital Albert Schweitzer founded and ran many years earlier in this century. I admired Bob enormously—his scientific competence, his budding clinical skills, his openness of manner, his marvelous gifts as a photographer, his intense and broad literary and philosophical interests, his love of music.

He supplied warmth to the Longwood Avenue area, as have countless other students, and teachers, and all those patients, feverishly hoping (sometimes hoping against hope) that more time, more life, will be theirs until, to appropriate a phrase of Emily Dickinson's, that time of "Zero at the Bone" arrives. Yes, every day a good deal of coldness quite definitely hovers over a number of those buildings near Longwood Avenue—but a fight, generating much heat, goes on, too, so that the snatching grip of coldness will, for a while, be stayed. □

Robert Coles is professor of psychiatry and medical humanities at HMS, and teaches courses in the Core Curriculum at Harvard College. He is also research psychiatrist to the University Health Services.

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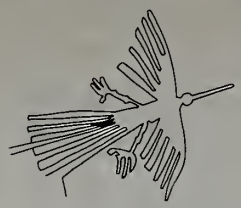

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